Within corporate limits

Dr Trevaskis

09800

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 25 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 477 Central Ave.

3. NAME OF DECEASED (Type or Print) (First) Nancy (Middle) Frances (Last) Adams
4. DATE OF DEATH (Month) Oct (Day) 14 (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Aug 15 1876
9. AGE last birthday 74 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Bedford Co. Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Robinson Smith
14. MOTHER'S MAIDEN NAME Hester A Bennett.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Jacob A. Adams - 477 Central Ave City

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

422.1 Immediate cause (a) Chronic Myocarditis — 7 yrs

Antecedent cause(s) (b) Arteriosclerosis — 2½ yrs

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Acute Coryza and bronchitis — 6 days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 1, 1950, to Oct 14, 1950, that I last saw the deceased alive on Oct 13, 1950, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE R. W. Trevaskis, Sr (Degree or title) M.D. ADDRESS Cumberland Md DATE SIGNED Oct 17-'50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Oct. 17, 1950
NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park
LOCATION (City, town, or county) Cumberland, (State) Md.

DATE REC'D BY LOCAL REG. Oct. 17, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR John J. Hofer, ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 20 1950
BUREAU T. S

Louis Brings

10733

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 15

| | |
|---|---|
| 1. PLACE OF DEATH · COUNTY: Allegany — MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Md — COUNTY: Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cresaptown — LENGTH OF STAY (in this place): 55 years | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cresaptown |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS: | STREET ADDRESS (If rural, give location): |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) Louisa | (Middle) Jeannette | (Last) Alexander | 4. DATE OF DEATH | (Month) Oct | (Day) 26 | (Year) 1950 |
| 5. SEX: F | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed | 8. DATE OF BIRTH: August 13, 1854 | 9. AGE last birthday: 96 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife | 10b. KIND OF BUSINESS OR INDUSTRY: Own home | 11. BIRTHPLACE (State or foreign country): Rawlings, Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.A | | | | |
| 13. FATHER'S NAME: Daniel McKenzie | 14. MOTHER'S MAIDEN NAME: Sarah Spencer | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: — | 17. INFORMANT AND ADDRESS: Mrs. Sarah Kommauf, Cresaptown, Md. | | | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| 450.0 | Immediate cause | (a) generalized arteriosclerosis | 20 years |
| 97 | Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) old age | |
| | | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐ |

| | | | | |
|---|---|---|---|---|
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE) |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? | | |

22. I hereby certify that I attended the deceased from Nov. 13, 1940, to Nov. 26, 1950, that I last saw the deceased alive on Nov. 20, 1950, and that death occurred at ..... m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| L Brings | (MD) | 57 Greene St. | 10-27-50 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | Oct. 28, 1950 | St. Ambrose Cemetery | Cresaptown | Md |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 27, 1950 | M. L. Sommerton | John J. Hofer, Cumberland, Md. | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 5 1951
BUREAU OF S

Within corporate limit
Dr. Fred Williams

09801

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1909 Bedford St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 1909 Bedford St.

3. NAME OF DECEASED (Type or Print) (First) Emily (Middle) Donges (Last) Allen
4. DATE OF DEATH (Month) Oct. (Day) 10, (Year) 1950
5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH 12-13-1881
9. AGE last birthday 68 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Meyersdale, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME George Donges
14. MOTHER'S MAIDEN NAME Anna Beal
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Mrs. Casper S. Brown Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 153x Immediate cause | (a) Carcinomatosis of | About |
| 46e Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Abdominal ~~viscera~~ viscera | 6 years |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Abdominal perineal resection Dec '44

19a. DATE OF OPERATION Six years ago
19b. MAJOR FINDINGS OF OPERATION Carcinoma of sigmoid
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-22, 1944 to 10-10, 1950, that I last saw the deceased alive on 10-8, 1950, and that death occurred at 6 10 P m., from the causes and on the date stated above.

SIGNATURE Wm. F. Williams (Degree or title) MD ADDRESS Cumberland DATE SIGNED 10-11-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 10-13, 1950
NAME OF CEMETERY OR CREMATORY Union Cemetery
LOCATION (City, town, or county) (State) Meyersdale, Pa.
DATE REC'D BY LOCAL REG. Oct. 12, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Charles L. George ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 18 1950
BUREAU V. S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09802

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): Grant St

| 3. NAME OF DECEASED (Type or Print) | (First) | (Middle) | (Last) | 4. DATE OF DEATH | (Month) | (Day) | (Year) |
|---|---|---|---|---|---|---|---|
| | Mary | W | Anderson | | 10 | 20 | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Widowed | Oct 23 1861 | 89 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired Farm Laborer | Various farms | Frostburg Maryland | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| David Anderson | Rachael Eckhart |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY No. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| No | None | Roy Anderson |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Myocardial failure | 10 days |
| 422.2 Antecedent cause(s) | | |
| 932 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Chr. Myocarditis | 3 yrs |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from Jan 21, 1950, to Oct 20, 1950, that I last saw the deceased alive on Oct 18, 1950, and that death occurred at 12:55 am., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Arthur F. Jones | M. D. | 110 S. Centre St. | Oct. 20, 1950 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 22, 1950 | Frostburg Memorial Cem. | Frostburg, Maryland |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 22, 1950 | Wistes K. Frantz, M.D. | J. K. Hurst | Frostburg, Maryland |

866W

RECEIVED
NOV 21 1950
BUREAU W. S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

09803

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; LENGTH OF STAY (In this place): 35 yrs. | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS: in route to Memorial Hospital | STREET ADDRESS (If rural give location): 117 Pa. Ave. |

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| James | W. | Andrews | Oct. | 24 | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE Last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | married | Nov. 23-1874 | 75 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| retired machinest | B&O.R.Ry. | Petersburg, Va. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| James Edward Andrews | Virginia Harrison Eannes |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY No. | 17. INFORMANT |
|---|---|---|
| no | 705 05 5280 | James Andrews (son) |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Coronary occlusion | at once |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Coronary sclerosis | ? |
| 420.1 940 | (c) Arteriosclerosis with hypertention. | ? |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | |

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒ |
|---|---|---|
| | | |

| 21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|
| H.V.Deming M.D. H. V. Deming M.D. | Cumberland, Md. | Oct.24-1950 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/27/1950 | Blandford Cemetery | Petersburg, Va. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 26, 1950 | Winter R. Frantz, M.D. | William H. Kight, Cumberland, Md. | |

32647

VS. A15A

RECEIVED
OCT 30 1950
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09804

Reg. Dist. No. 10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Allegheny

City or town: Rural - Mail Savage
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 weeks

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Allegheny

City or town: Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. Paw Paw W.Va R.D.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

**3.(a) FULL NAME:** Henry E Baker

**3.(b) Social Security Number:** 201-01-4986

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife: Elsie Hemshell Baker

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): Feb 26, 1879

**8. AGE:** Years: 71 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Somerset Co. Md.
(Town, county, and state)

10. Usual occupation: Caretaker at Social Club

11. Industry or business:

FATHER
12. Name: John Baker
13. Birthplace: Pa.

MOTHER
14. Maiden name: Lydia Shumaker
15. Birthplace: Pa.

16. Informant: Mrs. Elsie Baker

Address: Paw Paw W.Va R.D.

17. Buried (Burial, cremation, or removal. Which?) Date thereof Oct. 15 1950 (mo.) (day) (year)

Cemetery or crematory: Union Cemetery

Location: Meyersdale Pa.

18. Funeral director: William Foye Price Marriott

Address: Meyersdale Pa.

19. Oct 12 1950 (Date rec'd by registrar) Vernia McDermitt Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 11th 1950 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 24 1950, to October 11 1950, and that I last saw him alive on October 11th 1950.

| | DURATION |
|---|---|
| Immediate cause of death: Chronic Myocarditis | Duration years |
| Due to: | |
| Due to: 47 2 | |
| Other conditions: Chronic Nephritis - Cardiac Dyspnea. | Duration years |

(Include pregnancy within 3 months of death)

131 lb

Major findings of operations:

Date of op.

Autopsy results: None performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William E. Marden M.D.
M. D. or other

Address: McDonough Md. Date signed 10/12-50

7409

Veronica
McDermitt

RECEIVED
OCT 16 1950

MARYLAND STATE DEPARTMENT OF HEALTH

09805

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 10

| | |
|---|---|
| 1. PLACE OF DEATH· COUNTY: Allegany MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED· STATE: Maryland COUNTY: Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage — LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | STREET ADDRESS (If rural, give location) |

| | | | | | |
|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) ELLEN | (Middle) DOLORES | (Last) BARRETT | 4. DATE OF DEATH | (Month) Oct. (Day) 23, (Year) 1950 |
| 5. SEX: male | 6. COLOR OR RACE: white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single | 8. DATE OF BIRTH: 11-2-1872 | 9. AGE last birthday: 77 yrs. | If under 1 year: Months / Days; If under 24 hrs.: Hours / Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework | 10b. KIND OF BUSINESS OR INDUSTRY: home | 11. BIRTHPLACE (State or foreign country): Mt. Savage, Md. | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME: Edward Barrett | 14. MOTHER'S MAIDEN NAME: Ellen Lavelle | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO.: none | 17. INFORMANT AND ADDRESS: Frances Barrett, Mt. Savage, Md. | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Myocarditis and | 6 mo. |
| 443X Antecedent cause(s) | Pulmonary Edema | 1 week |
| 92 b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Mitral Stenosis | 5 years |
| | (c) Vascular Hypertension | 5 years |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from August, 1950, to Oct 21, 1950, that I last saw the deceased alive on Oct 21, 1950, and that death occurred at 7:30 P.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| William E. Moseley | | Mt Savage Md. | October 24-1950 |

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: 10-26-50 | NAME OF CEMETERY OR CREMATORY: St. Patrick's Cemetery | LOCATION (City, town, or county) (State): Mt. Savage, Md. |
| DATE REC'D BY LOCAL REG.: Oct 27, 1950 | REGISTRAR'S SIGNATURE: Veronica McDermitt per [illegible] | 24. FUNERAL DIRECTOR: J. R. Durst, Frostburg, Md. | ADDRESS |

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 27 1980
BUREAU OF

Within corporate limits DR. VAN ORMER

09806

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 27 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE WEST VIRGINIA COUNTY Hardy
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN MOOREFIELD
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) MARY (Middle) (Last) BEAN
4. DATE OF DEATH (Month) OCT. (Day) 23 (Year) 1950
5. SEX FEMALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW
8. DATE OF BIRTH NOV. 11/1866
9. AGE last birthday 83 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) OHIO Athens
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME WILLIAM STARKEY
14. MOTHER'S MAIDEN NAME CHARITY DURANT
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pneumonia, Primary, atypical — INTERVAL BETWEEN ONSET AND DEATH 28 days

492X

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

109

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized arteriosclerosis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 24 Sept. 1950, to 23 Oct. 1950, that I last saw the deceased alive on 23 Oct. 1950, and that death occurred at 5:55 P.m., from the causes and on the date stated above.

SIGNATURE W. Alfred Van Ormer (Degree or title) ADDRESS Cumberland, Md DATE SIGNED 24 Oct 50

23. BURIAL, ~~CREMATION REMOVAL (Specify)~~ Burial
DATE THEREOF 10/26/50
NAME OF CEMETERY OR CREMATORY Olivet Cemetery
LOCATION (City, town, or county) Moorefield Hardy (State) W. Va.
DATE REC'D BY LOCAL REG. Oct. 25, 1950
REGISTRAR'S SIGNATURE Arnter K. Frantz, M.D.
24. FUNERAL DIRECTOR P. E. Florence & Son ADDRESS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
NOV 1 1950
BUREAU P. S

Dr. FAW

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09807

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY: ALLEGANY
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 59 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND
COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
STREET ADDRESS (If rural, give location): 334 FAYETTE STREET

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| MARY | ELLEN | BOPST | October | 14 | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| FEMALE | WHITE | SINGLE | DEC. 16 1870 | 79 yrs. | 9 | 28 | | |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher Retired
10b. KIND OF BUSINESS OR INDUSTRY: Teaching School
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOSHUA BOPST
14. MOTHER'S MAIDEN NAME: JULIA FLEMING

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

153X Immediate cause (a) Adeno-Carcinoma sigmoid Colon — Interval Between Onset and Death: Abt. 4 yrs.

46e Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Senility

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Aug 19, 1950 | Adeno carcinoma sigmoid with general metastasis | Yes ☐ No ☑ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | CITY OR TOWN | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from Aug 16, 1950, to Oct 14, 1950, that I last saw the deceased alive on Oct 14, 1950, and that death occurred at 8:15 P.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Wyle M Faw Jr. | M. D. | Cumberland Md. | |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | 10/17/50 | Mt. Olivet Cemetery | Frederick | Maryland |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 16, 1950 | Hunter R Crouch, M.D. | Louis Stein, Inc. | Cumberland, Md. |

V 3491

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 2 1950
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Within corporate limits

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# MARYLAND STATE DEPARTMENT OF HEALTH

09808

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 2 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 332 Davidson Street

3. NAME OF DECEASED (Type or Print): (First) MOSES (Middle) (Last) BOWERS

4. DATE OF DEATH: (Month) 10- (Day) 15- (Year) 1950

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: May 24, 1936

9. AGE last birthday: 14 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: High School

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: HARRY C. BOWERS

14. MOTHER'S MAIDEN NAME: ARRENE ORNDORF

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Harry C. Bowers, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Respiratory Arrest | Hrs. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Poliomyelis Bulbar | 36 hrs. |
| 0800 36 | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 13, 1950, to Oct 16, 1950, that I last saw the deceased alive on Oct 16, 1950, and that death occurred at 9:45 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Wm. Lee Wood M.D. — ADDRESS: 40 Baltimore St Hancock Md. — DATE SIGNED: 10-16

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: 10/17/1950 | NAME OF CEMETERY OR CREMATORY: House of David Cemetery | LOCATION (City, town, of county) (State): Hancock, Md.

DATE REC'D BY LOCAL REG.: Oct 16 1950 | REGISTRAR'S SIGNATURE: Hunter R Bratt M.D.

24. FUNERAL DIRECTOR — ADDRESS: William H. Kight, Cumberland, Md.

RECEIVED
OCT 24 1950
BUREAU V. S

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09809

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland, COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ~~Narrows Park~~ Near, Cumberland, ~~Md~~ Rural
STREET ADDRESS (If rural, give location) Rt. # 6, Narrows Park

3. NAME OF DECEASED (Type or Print) (First) DAISY (Middle) MAY (Last) BOWSER
4. DATE OF DEATH (Month) Oct. (Day) 13, (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH May 12, 1882
9. AGE last birthday 68 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Homestrome
11. BIRTHPLACE (State or foreign country) Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME Lloyd Brant
14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Joseph L. Bowser Rt. #6 Narrows Park

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocarditis

443X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension

93d (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE — (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — ~~(CITY OR TOWN)~~ (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
INJURY OCCURRED While at Work ☐ ~~Not While~~ At work ☐
~~HOW DID INJURY OCCUR?~~

22. I hereby certify that I attended the deceased from 6/15, 1948, to 10/13 1950, that I last saw the deceased alive on 10/13 1950, and that death occurred at 7:05 B m., from the causes and on the date stated above.

SIGNATURE John K. Rozum (Degree or title) M D ADDRESS Cumberland Md DATE SIGNED 10/16/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 10/16/50
NAME OF CEMETERY OR CREMATORY Rose Hill Cem.
LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. Oct. 16, 1950
REGISTRAR'S SIGNATURE Wrate R Trantz, M.D.
24. FUNERAL DIRECTOR Charles L. George ADDRESS Cumberland, Md.

RECEIVED
OCT 24 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09810

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) All of Life; HOSPITAL OR INSTITUTION OR STREET ADDRESS 9 W. Oldtown Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 9 W. Oldtown Rd.

3. NAME OF DECEASED (Type or Print): (First) Mamie (Middle) V. (Last) Boyd

4. DATE OF DEATH (Month) (Day) (Year): 10/26/50 19

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 11/18/1876

9. AGE last birthday: 74 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Mln.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Cumberland, Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Michael Kean

14. MOTHER'S MAIDEN NAME: Anna Studbart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Della E. Kean 9W. Oldtown Rd.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

332X

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized Arteriosclerosis ?

83b

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Infirmities of age

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-1-14, 1950, to 10-26-, 1950, that I last saw the deceased alive on 10-25, 1950 and that death occurred at 12 Noon m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

W. T. Williams M.D. Cumberland 10-28-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: 10/30/50

NAME OF CEMETERY OR CREMATORY: St Patrick Cem

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Oct 28, 1950

REGISTRAR'S SIGNATURE: Hunter R. Tantz, M.D.

24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli Cumberland, Md.

RECEIVED
OCT 31 1950
BUREAU

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09811

# CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg — LENGTH OF STAY (in this place): | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital | STREET ADDRESS (If rural, give location): Center St. |

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| CHARLES | FRANKLIN | BROWN | Oct. | 30 | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | widowed | 8-28-1868 | 82 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| retired plumber | self-employed | West Virginia | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Smith Brown | Anna Gallaher |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY No. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| | none | Mrs. Katie Brode, Detroit, Mich. |

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Acute Cardiac Dilatation | 1 hr |
| Antecedent cause(s) | (b) Chr Myocarditis | 3 yrs |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (c) | |

422.2
422

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from Oct 30, 1950, to Oct 30, 1950, that I last saw the deceased alive on Oct 30, 1950, and that death occurred at 4:30 A m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| W O M Lane MD | | Frostburg Md | 10-31-50 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-1-50 | Fbg. Memorial Park | Frostburg, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 11-1-50 | Mrs. Nancy N Roe | J. R. Durst, Frostburg, Md. | |

VS-A15

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RECEIVED
NOV 6 1950
BUREAU T. B

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

09812

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

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VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Md — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 216 Oak St.

3. NAME OF DECEASED (Type or Print): (First) Ethel (Middle) L (Last) Burns

4. DATE OF DEATH: (Month) (Day) (Year) 10/15/50 19

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: 2/15/1887

9. AGE last birthday: 63 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Mln.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Rector Rock Ark.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas C. Smith

14. MOTHER'S MAIDEN NAME: Perlie Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: May Kester 216 Oak St Cumberlan

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Vascular Accident — 48 hrs

443X Antecedent cause(s)

932 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension Cardio vascular disease — 4 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office hldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 19, 1949, to Feb 19, 1949, that I last saw the deceased alive on Oct. 14, 1950, and that death occurred at 6 30 a m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

Arthur F. Jones M.D. — 110 S. Centre St. — Oct. 16, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: 10/17/50 | NAME OF CEMETERY OR CREMATORY: Eckhart Cemetery | LOCATION (City, town, or county) (State): Eckhart, Md.

DATE REC'D BY LOCAL REG. Oct 16, 50 | REGISTRAR'S SIGNATURE: Hunter R. Crouch, M.D. | 24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli Cumberland, Md.

RECEIVED
OCT 24 1950
BUREAU V. S

Within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09813

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland,; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 73 Greene St.,

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland,; STREET ADDRESS (If rural, give location) 73 Greene St.,

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) CARNEY (Last) CARBINE

4. DATE OF DEATH: (Month) Oct. (Day) 1, (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Aug. 3, 1872

9. AGE last birthday: 78 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Domestic Own Home

11. BIRTHPLACE (State or foreign country): Bloomington, Md.

12. CITIZEN OF WHAT COUNTRY: U. S.

13. FATHER'S NAME: Darby E. Carney

14. MOTHER'S MAIDEN NAME: Bridget Reddington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs. Louis Gellner Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

334x Immediate cause (a) Apoplexy — Interval Between Onset and Death: 2 days

82a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Essential Hypertension — 4 years

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sep 30, 1950, to Oct 1, 1950, that I last saw the deceased alive on Oct 1, 1950, and that death occurred at 9:00 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Ralph G. Bacon M.D. 62 Greene St. Cumberland Md.

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: Oct. 4, 1950 | NAME OF CEMETERY OR CREMATORY: S. S. Peter & Paul | LOCATION (City, town, or county) (State): Cumberland, Md. 10-2-50

DATE REC'D BY LOCAL REG.: Oct. 2, 1950 | REGISTRAR'S SIGNATURE: Walter R. Dantz, M.D. | 24. FUNERAL DIRECTOR ADDRESS: H. Wayne George Cumberland, Md.

VS. A15

RECEIVED
OCT 10 1950
BUREAU V. S

Within corporate limits

M

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09814

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 211 S. Allegany St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 211 S. Allegany St.

3. NAME OF DECEASED (Type or Print) (First) Thomas (Middle) A (Last) Carscaden
4. DATE OF DEATH (Month) Oct. (Day) 10 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Aug 12 1875
9. AGE last birthday 75 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Master Plumber
10b. KIND OF BUSINESS OR INDUSTRY Self
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thomas A Carscaden
14. MOTHER'S MAIDEN NAME Mary Jane Fawcett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Mrs. Elizabeth R. Carscaden

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Exhaustion & Cerebral Hemorrhage

443X

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension Heart disease

93d

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov, 1949, to Oct 10, 1950, that I last saw the deceased alive on Oct 9, 1950, and that death occurred at 2:30 Oct 10 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
F. Alan G. Murray M.D. Cumberland Md.

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Oct 12-50
NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
LOCATION (City, town, or county) (State) Cumberland, Allegany Md.

DATE REC'D BY LOCAL REG. Oct. 12, 1950
REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.
24. FUNERAL DIRECTOR Louis Stein, Inc. ADDRESS Cumberland, Md.

34849

RECEIVED
OCT 18 1950
BUREAU V. S

Dr. Schindler

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09815

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY COUNTY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD
LENGTH OF STAY (in this place) 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE WEST VIRGINIA, MINERAL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN PINTO
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) MARTHA (Middle) B (Last) CASE
4. DATE OF DEATH (Month) OCTOBER (Day) 8, (Year) 1950
5. SEX FEMALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED
8. DATE OF BIRTH Oct 3, 1888
9. AGE last birthday 62 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) PA
12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME GEORGE BAILEY
14. MOTHER'S MAIDEN NAME ELIZABETH DUNBAR
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS MEMORIAL Hospital. Cumberland, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Coronary Thrombosis | 8 hours |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Hypertensive C.V. Disease | years |
| | (c) | |

420.1
93d

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1947 to Oct 8, 1950, that I last saw the deceased alive on Oct 8, 1950, and that death occurred at 3 30 p.m., from the causes and on the date stated above.

SIGNATURE B. M. Schindler (Degree or title) M.D. ADDRESS 41 Greenett, Cumberland Md DATE SIGNED 10/8/50.

23. BURIAL, CREMATION, REMOVAL (Specify) Removal
DATE THEREOF Oct 10 1950
NAME OF CEMETERY OR CREMATORY Reading, Pa.
LOCATION (City, town, or county) Williamsport (State) Pa.

DATE RECD BY LOCAL REGISTRAR'S SIGNATURE
+ Cremation Oct. 9, 1950 Hunter R Trantz, M.D.
24. FUNERAL DIRECTOR Louis Stein, Inc. ADDRESS Cumberland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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OCT 13 19
BUREAU

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09816

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 20 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 1407 Bedford Rd

3. NAME OF DECEASED (Type or Print) (First) Pendleton (Middle) Ambrose (Last) Cessna

4. DATE OF DEATH (Month) Oct (Day) 11 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Mar 14 1868
9. AGE last birthday 82 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY Farming Fur farm
11. BIRTHPLACE (State or foreign country) Bedford Valley, Pa
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME James B. Cessna Salesman - Automobiles
14. MOTHER'S MAIDEN NAME Margaret Elliott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. 212-12-8237 ~~None~~
17. INFORMANT Mrs Pearl Dicken, Rt 3 Cumb. Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

904.0 Immediate cause (a) Fracture of lumbar Spine — INTERVAL BETWEEN ONSET AND DEATH: 5 weeks

Antecedent cause(s)

186a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) Accident
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
(CITY OR TOWN) Cumberland (COUNTY) Allegany (STATE) Maryland
TIME OF INJURY (Month) 9 (Day) 8 (Year) 50 (Hour) m.
INJURY OCCURRED While at Work ☑ Not While At work ☐
HOW DID INJURY OCCUR? Fell in home

22. I hereby certify that I attended the deceased from 9-9, 1950, to 10-11, 1950, that I last saw the deceased alive on 10-11, 1950, and that death occurred at 4:00 a m., from the causes and on the date stated above.

SIGNATURE Ralph W. Ballin (Degree or title) M.D. ADDRESS 62 Greene St. Cumberland Md DATE SIGNED 10-12-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Oct 13, 1950
NAME OF CEMETERY OR CREMATORY Bethel Methodist Cem.
LOCATION (City, town, or county) Bedford Valley (State) Pa.

DATE REC'D BY LOCAL REG. Oct. 13, 1950
REGISTRAR'S SIGNATURE Vinton R Frantz, M.D.
24. FUNERAL DIRECTOR John J Hafer ADDRESS Cumberland Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 18 1950
BUREAU V. S.

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09817

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Allegany — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 1 yr.
HOSPITAL OR INSTITUTION OR STREET ADDRESS County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland Rural
STREET ADDRESS (If rural, give location) Route 4, Oldtown Road

3. NAME OF DECEASED (Type or Print): (First) Ida (Middle) V. (Last) Christie

4. DATE OF DEATH: (Month) Oct. (Day) 21 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Feb 1st - 1866

9. AGE last birthday: 84 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard Zimmerly

14. MOTHER'S MAIDEN NAME: Jermina Dennison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Maurice Long, Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Myocardial failure | 7 days |
| 420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Coronary sclerosis | 5 yrs |
| 94a | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 25, 1949, to Oct. 21, 1950, that I last saw the deceased alive on Oct. 20, 1950, and that death occurred at 2 15 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

Arthur F. Jones M.D. — 110 S. Centre St. — Oct. 23, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Oct 24-1950 — NAME OF CEMETERY OR CREMATORY: Davis Memorial — LOCATION (City, town, or county) (State): Cumberland Md.

DATE REC'D BY LOCAL REG. Oct. 24, 1950 — REGISTRAR'S SIGNATURE: Winter L. Lantz, M.D.

24. FUNERAL DIRECTOR — ADDRESS: Louis Stein Inc. Cumberland

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Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

09818

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

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The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully.

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VS. A15A

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 2 hrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE W.Va.; COUNTY Hardy; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Moorefield W.Va.; STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Elizabeth (Middle) DeSales (Last) Cleaver

4. DATE OF DEATH: (Month) Oct. (Day) 19 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Oct. 25, 1885

9. AGE last birthday: 64 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Piedmont, W Va.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John Gilmore

14. MOTHER'S MAIDEN NAME: Mary Keady

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Allegany Hospital record

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Coronary Occlusion | at once |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Angina Pectoris | 7½ hrs. |
| | (c) Arterial Sclerosis | ? |

420.1

94a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V.Deming M.D. H. V. Deming M.D. Cumberland, Md. Oct.19-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF Oct 23, 1950

NAME OF CEMETERY OR CREMATORY St Peters Cemetery

LOCATION (City, town, or county) (State) Western Port Md.

DATE REC'D BY LOCAL REG. Oct. 19, 1950

REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR ADDRESS Ellsworth & Bare Western Port, Md.

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Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

09819

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland,; LENGTH OF STAY (in this place) MARYLAND; HOSPITAL OR INSTITUTION OR STREET ADDRESS 310 Harrison St.,

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland,; STREET ADDRESS (If rural, give location) 310 Harrison St.,

3. NAME OF DECEASED (Type or Print): (First) ROBERT (Middle) ------- (Last) CRONE

4. DATE OF DEATH: (Month) Oct. (Day) 13 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Nov. 27, 1878

9. AGE last birthday: 71 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tailor

10b. KIND OF BUSINESS OR INDUSTRY: Crystal Laundry

11. BIRTHPLACE (State or foreign country): Columbia, Penna.

12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: Frank Crone

14. MOTHER'S MAIDEN NAME: Lucretia Sands

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Mrs. Mary Crone Cumb. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiac fracture. — Interval between onset and death: 6 mo.

422.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d (b) Arteriosclerotic cardiovascular disease — 2 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept., 1950, to 10-13., 1950 that I last saw the deceased alive on 10-13., 1950, and that death occurred at 1:30 P. m., from the causes and on the date stated above.

SIGNATURE: John A Dyer (Degree or title) M.D. ADDRESS 247 Va Ave DATE SIGNED 10-16-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE THEREOF 10/16/50; NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park; LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. Oct 16 1950; REGISTRAR'S SIGNATURE Hunter R Dantz, M.D.

24. FUNERAL DIRECTOR: H. Wayne George; ADDRESS: Cumberland, Md.

36088

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OCT 24 1950
BUREAU V. S

Outside of City Limits

M

MARYLAND STATE DEPARTMENT OF HEALTH

09820

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural in auto near Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Dead on arrival at Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE W.Va. COUNTY Hampshire
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Paw Paw,
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) John (Middle) (Last) Delawder
4. DATE OF DEATH (Month) Oct (Day) 21 (Year) 1950
5. SEX Male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH Jan 28 1893
9. AGE last birthday 57 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer, Keystone Tanning & Glue Co.
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Petersburg, W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Benjiam Delawder
14. MOTHER'S MAIDEN NAME Anna Riggleman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 232-10-2469
17. INFORMANT Mrs Grace Delawder, Paw Paw W. Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH 3/4 hrs

919.1 Immediate cause (a) Intrathoracic hemorrhage

184 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Two 12 guage shot gun slugs in chest.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) farm Ganes Milburn
(CITY OR TOWN) 7 miles south of Paw Paw. (COUNTY) Hamshire (STATE) W.Va.
TIME OF INJURY (Month) (Day) (Year) (Hour) Oct.21/50-9A. m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Turkey hunting Accidently shot by John E.Twigg

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H. V. Deming M.D. ADDRESS Cumberland, Md. DATE SIGNED Oct 21 -1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Oct24 1950
NAME OF CEMETERY OR CREMATORY Camp Hill Cemetery
LOCATION (City, town, or county) (State) Paw Paw W. Va.

DATE REC'D BY LOCAL REG. Oct. 22, 1950
REGISTRAR'S SIGNATURE Arnter R. Frantz, M.D.
24. FUNERAL DIRECTOR W. D. Parks, ADDRESS Berkeley Springs W Va

98817

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

T

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NOV 1 1950
BUREAU V. S

Within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH

09821

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 50 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 710 Shriver Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 710 Shriver Ave.

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) (Last) Dreyer
4. DATE OF DEATH: (Month) Oct. (Day) 3 (Year) 1950

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widow
8. DATE OF BIRTH: Dec. 6-1862
9. AGE last birthday: 87 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Frostburg, Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Krapft
14. MOTHER'S MAIDEN NAME: Barbara Hauger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Robt. H. Dreyer

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Coronary occlusion | 5 min. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Arteriosclerosis | ? |
| | (c) | |

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|
| H.V. Deming M.D. H. V. Deming M.D. | Cumberland, Md. | Oct. 3-1950 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 6, 1950 | Trinity Lutheran Cemetery | Cumberland Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 5, 1950 | Winter K. Krantz, M.D. | John J. Hofer, Cumberland, Md. | |

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OCT 10 1950
BUREAU V. S

Within corporate limits

DR. FAW

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09822

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD.
LENGTH OF STAY (in this place) 10 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND.
STREET ADDRESS (If rural, give location) 765 FAYETTE STREET

3. NAME OF DECEASED (Type or Print) (First) THOMAS L. (Middle) (Last) DUGAN

4. DATE OF DEATH (Month) OCTOBER (Day) 14 (Year) 1950

5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED
8. DATE OF BIRTH JULY 8 1883
9. AGE last birthday 67 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Air Inspector
10b. KIND OF BUSINESS OR INDUSTRY B. & O.R.R. Co.
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME MICHAEL J. DUGAN
14. MOTHER'S MAIDEN NAME MARGARET WARD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY No. 705-09-9653
17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 560.0 Immediate cause | (a) Probable pulmonary infarction | Immediate |
| 122a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Bilateral Hernia Repair | Oct 7, 1950 |
| | (c) Obesity | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION Oct 7, 1950
19b. MAJOR FINDINGS OF OPERATION Bilateral inguinal hernia
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 6, 1950, to Oct 14, 1950, that I last saw the deceased alive on Oct 13, 1950 and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE Wyhe M Faw Jr (Degree or title) M. D. ADDRESS Cumberland Md DATE SIGNED Oct 14, 1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 10-18-1950
NAME OF CEMETERY OR CREMATORY St. Patricks
LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. Oct. 16, 1950
REGISTRAR'S SIGNATURE Hunter R Trantz, M. D.
24. FUNERAL DIRECTOR Charles L. George - Cumberland, Md ADDRESS

31847

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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OCT 24 1950
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Within corporate limit

09823

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Barton
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Baby (Middle) Girl (Last) Dye
4. DATE OF DEATH (Month) Oct. (Day) 24 (Year) 1950
5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH Oct. 23, '50
9. AGE last birthday yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James Dye
14. MOTHER'S MAIDEN NAME Phyllis James
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT AND ADDRESS Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Prematurity

776X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

159 (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....m., from the causes and on the date stated above.

SIGNATURE W. Roya Hodges (Degree or title) ADDRESS Cumberland, Md. DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Cremation
DATE THEREOF Oct. 26, 1950
NAME OF CEMETERY OR CREMATORY Memorial Hospital
LOCATION (City, town, or county) (State) Cumberland, Md.
DATE REC'D BY LOCAL REG. Oct. 26, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Memorial Hosp., Cumberland, Md. ADDRESS

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09824

# CERTIFICATE OF DEATH

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Barton - rural; LENGTH OF STAY (in this place) 70 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS 1 mile east of Barton

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Barton rural; STREET ADDRESS (If rural, give location) 1 mile east of Barton

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) ELIZABETH (Last) FAZENBAKER

4. DATE OF DEATH: (Month) Oct (Day) 29 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Jan 3, 1872

9. AGE last birthday: 78 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Neville Hyder McCloud

14. MOTHER'S MAIDEN NAME: Martha E. Simpson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service) - - -

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Charles Fazenbaker

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Lobar Pneumonia | 5 Days |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (4222 / 108) | (b) Chronic Myocarditis and Myocardial Degeneration Not Specified as rheumatic | 2 Years |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): None

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 2, 1948, to Oct 24, 1950, that I last saw the deceased alive on Oct. 29, 1950, and that death occurred at 3:15 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Paul R. Wilson, M.D. ADDRESS Piedmont W. Va DATE SIGNED 31 Oct. 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE THEREOF: 11/1/50; NAME OF CEMETERY OR CREMATORY: FAZEN BAKER Cem.; LOCATION (City, town, or county) (State): Barton Md.

DATE REC'D BY LOCAL REG. 11/1/50; REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR: E. S. Boal ADDRESS: Westernport, Md.

VS. A15

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NOV 6 1950
BUREAU V. S

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09825

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

I

**1. PLACE OF DEATH**
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 4yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 26 Virginia Ave

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 26 Virginia Ave.

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Stella | Florence | Fazenbaker | 10/12/50 | | 19 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | Widowed | I/7/I876 | 74 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | None | Swanton, Md. | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| George S. Hawk | Mary Ellen Kight |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|---|
| NO | NO | None | Mrs. J.C.Spring 26 Virginia Ave. |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| 442X Immediate cause | (a) Cardio Vascular Renal | |
| Antecedent cause(s) | | |
| 131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Disease | ? |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from 8.20, 1950, to 10.12., 1950, that I last saw the deceased alive on 10.12., 1950, and that death occurred at 7 P m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Wm. F. Williams | M.D. | Cumberland | 10,13,50 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | I0/I5/50 | Philos Cemetery | Westernport, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 14, 1950 | Walter K. Frantz, M.D. | James F. Scarpelli | Cumberland, Md. |

RECEIVED
OCT 18 1950

DR. W.F. WILLIAMS

Within corporate limits

M

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09826

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD.; LENGTH OF STAY in this place 127 DAYS; HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE WEST VIRGINIA; COUNTY MORGAN; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN PAW PAW, W.VA.; STREET ADDRESS (If rural, give location) ✓

3. NAME OF DECEASED (Type or Print): (First) WILLIE (Middle) MARIE (Last) FIRLIE

4. DATE OF DEATH: (Month) OCT. (Day) 5. (Year) 1950

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED

8. DATE OF BIRTH: FEB. 8, 1889

9. AGE Last birthday: 61 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: at Home

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: RICHARD KAUFFMAN

14. MOTHER'S MAIDEN NAME: SUSAN WERTZ

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL -CUMBERLAND, MD.

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

442x **Immediate cause** (a) Chronic Hypertensive

131a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cardio Vascular Renal Disease

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-1-, 1950, to 10-5-, 1950, that I last saw the deceased alive on 10-4-, 1950, and that death occurred at 2:45 A.m. from the causes and on the date stated above.

SIGNATURE (Degree or title) W.F. Williams M.D. ADDRESS Cumberland DATE SIGNED 10-5-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF Oct. 7, 1950 | NAME OF CEMETERY OR CREMATORY Rose Hill Cem. | LOCATION (City, town, or county) (State) Cumberland, Maryland

DATE REC'D BY LOCAL REG. Oct. 7, 1950 | REGISTRAR'S SIGNATURE Curtis R. Dantz M.D. | 24. FUNERAL DIRECTOR Louis Stein Inc. | ADDRESS Cumberland Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

RECEIVED
OCT 10 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

09827

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 8 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: rural Cumberland
STREET ADDRESS (If rural give location): 20 Poplar St. Bowling Green

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| William | H. | Frazier | Oct | 29 | 19 50 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | married | Sept.12-1894 | 56 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Printer | Evening Times | Barton, Md | U.S.A. |

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| yes W.W.I | 214-05-4896 | Hospital records. |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| Immediate cause | (a) | Intra cerebellar hemorrhage due to | 8 days |
| 331X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 83a | (b) | sclerosis | ? |
| | (c) | | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☒ No ☐ |

| 21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|
| H.V.Deming M.D. H V Deming M.D. | Cumberland,Md. | Oct.29-1950 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-1-1950 | Rose Hill Cem. | Cumberland, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Nov 1, 1950 | Hunter R Trout, M.D. | Charles L. George | Cumberland, Md. |

31014

RECEIVED
NOV 7 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

09828

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH
COUNTY: Allegany
MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: W.Va.
COUNTY: Hampshire
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Romney
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) Nellie (Middle) H (Last) Ganoe

4. DATE OF DEATH: (Month) Oct. (Day) 30 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married

8. DATE OF BIRTH: June 1913

9. AGE last birthday: 37 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Apple picker

10b. KIND OF BUSINESS OR INDUSTRY: Apple orchard.

11. BIRTHPLACE (State or foreign country): W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Gilbert Starnes

14. MOTHER'S MAIDEN NAME: Ada Poland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 230-30-8750

17. INFORMANT: Memorial Hospital record.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

342X **Immediate cause** (a) Brain abscess, left temporal lobe — about 10 days

**Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

80a (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V.Deming M.D. H. V. Deming M.D. Cumberland, Md. Oct.31-1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: Nov.1, 1950

NAME OF CEMETERY OR CREMATORY: Three Churches Cem.

LOCATION (City, town, or county) (State): Three Churches, W. Va.

DATE REC'D BY LOCAL REG.: Oct. 31, 1950

REGISTRAR'S SIGNATURE: Hunter R Evans, M.D.

24. FUNERAL DIRECTOR ADDRESS: Meryl Combs, Romney, W. Va.

866 VV

RECEIVED
NOV 7 1960
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

09829

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; LENGTH OF STAY (In this place): 20 yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS: 429 Beall St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; STREET ADDRESS (If rural give location): 429 Beall St.

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| John | Carroll | Gilmore | Oct. | 16 | 19 50 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | married | July 16-1895 | 55 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Weighmaster | B&O.R.Ry. | Martinsburg, W.Va. | U.S.A. |

13. FATHER'S NAME: John Patrick Gilmore

14. MOTHER'S MAIDEN NAME: Louise Cunningham

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| Yes. W.W.I | 705-05-8043 | Charles B. Tasker |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| Immediate cause | (a) | Coronary occlusion | at once |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | Coronary sclerosis | ? |
| | (c) | | |

420 1
940

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒ |
|---|---|---|
| | | |

| 21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| H.V. Deming M.D. | H. V. Deming M.D. | Cumberland, Md. | Oct. 16-1950 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 19, 1950 | Hillcrest Cemetery | Cumberland, Maryland |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 18, 1950 | Hunter K. Hantz, M.D. | James F. Scarpelli | Cumberland, Md. |

26647

VS. A15A

RECEIVED
OCT 24 1950
BUREAU T. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09830

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing; STREET ADDRESS (If rural, give location) Main St

3. NAME OF DECEASED (Type or Print): (First) Peter (Middle) C (Last) Green

4. DATE OF DEATH: (Month) Oct (Day) 26th (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Divorced

8. DATE OF BIRTH: Aug 10-1863

9. AGE last birthday: 87 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watch Maker

10b. KIND OF BUSINESS OR INDUSTRY: Own Business

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Matthew Green

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs Madona Zigenfelter

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Ty Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 15 min — 420.1

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) — 94a

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1950, to Oct 26, 1950, that I last saw the deceased alive on Oct 26, 1950, and that death occurred at 5:15 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Arthur F. Jones — ADDRESS: 110 S. Centre St — DATE SIGNED: Oct. 30, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Oct 30-1950 — NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery — LOCATION (City, town, or county) (State): Lonaconing Md

DATE REC'D BY LOCAL REG.: Oct 30, 1950 — REGISTRAR'S SIGNATURE: Hunter C. Frantz, M.D.

24. FUNERAL DIRECTOR: M. Eichhorn — ADDRESS: Lonaconing, Md

15632

RECEIVED
NOV 7 1950

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

# MARYLAND STATE DEPARTMENT OF HEALTH

09831

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 307 Water St.,

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland,
STREET ADDRESS (If rural, give location) 307 Water St.,

3. NAME OF DECEASED (Type or Print) (First) MARTIN (Middle) HENRY (Last) HAGER
4. DATE OF DEATH (Month) Oct. (Day) 12, (Year) 1950
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Feb. 3, 1874
9. AGE last birthday 76 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired air inspector
10b. KIND OF BUSINESS OR INDUSTRY B. & O. Rwy.
11. BIRTHPLACE (State or foreign country) Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME William H. Hager
14. MOTHER'S MAIDEN NAME Mary McDonald
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 705-09-9680
17. INFORMANT AND ADDRESS James W. Hager Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| 422.1 | Immediate cause | (a) Chronic myocarditis | 2 years |
| 93d | Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Arteriosclerosis | 3 years |
| | | (c) | |

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Lhemiplegia — 4 mos

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 1st, 1950, to Oct 12, 1950, that I last saw the deceased alive on Oct 11, 1950, and that death occurred at 2 A. m., from the causes and on the date stated above.

SIGNATURE R. W. Trevaskis, Sr (Degree or title) ADDRESS DATE SIGNED Oct 14-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 10/14/50
NAME OF CEMETERY OR CREMATORY Rose Hill Cem.
LOCATION (City, town, or county) (State) Cumberland, Md.
DATE REC'D BY LOCAL REG. Oct. 14, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Charles L. George ADDRESS Cumberland, Md.

31847

RECEIVED
OCT 18 1950
BUREAU V. S

Evidence for addition in 21 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

09832

Reg. Dist. No. 4

FHM No. G 12 NOV 16 1950

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 9 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md.; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural give location) 610 N. Ann Place

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Jessie | M. | Handell | Oct. | 26 | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| female | white | married | July 7-1864 | 86 yrs. | | | | |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Sandy Lake, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nathan Patton

14. MOTHER'S MAIDEN NAME: Cleora Thompson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY No.: ----

17. INFORMANT: Memorial Hospital records.

### 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Acute cardiac failure | at once |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Chronic myocarditis | several yrs. |
| | (c) arteriosclerosis | ? |

903.9 422.1 186a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. fractured left femur. — 9 days

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): (CITY OR TOWN) Cumberland (COUNTY) Allegany (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour): m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR? Fall - same level (11-15-50 akc)

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| H.V.Deming M.D. | H. V. Deming M. D. | Cumberland, Md. | Oct. 27-1950 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 29 1950 | Rose Hill Cemetery | Cumberland, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 28, 1950 | Hunter R Beatty M.D | William H. Kight | Cumberland, Md. |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
NOV 1 1950
BUREAU OF

09833

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 6

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport-Rural
LENGTH OF STAY (in this place) 50 yts
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1 Mi. N. Westernport

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westernport
STREET ADDRESS (If rural give location) 1 mi. N. of Westernport

3. NAME OF DECEASED (Type or Print) (First) William (Middle) (Last) Harris
4. DATE OF DEATH (Month) Oct. (Day) 1 (Year) 1950
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH Mar. 3, 1880
9. AGE last birthday 70 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Thomas S. Harris
14. MOTHER'S MAIDEN NAME Anna Alexander
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 0
17. INFORMANT Lewis Harris

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Coronary Occlusion | At once |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Arterioslerosis (marker) | ? |
| | (c) | |

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V. Deming M.D. (Degree or title) H. V. Deming M.D. ADDRESS Cumberland, Md. DATE SIGNED Oct. 1-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 10/3/50
NAME OF CEMETERY OR CREMATORY Philos Cem.
LOCATION (City, town, or county) Westernport, Md. (State)

DATE REC'D BY LOCAL REG. Oct 3/50
REGISTRAR'S SIGNATURE A. Gaffenbaker M.D.
24. FUNERAL DIRECTOR Ellsworth S. Boal, ADDRESS Westernport, Md.

XVX99

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
OCT 11 1950

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09834

# CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

VS. A15

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 103 Frost Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 103 Frost Avenue

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) ELIZABETH (Last) HENCKEL

4. DATE OF DEATH: (Month) Oct. (Day) 4, (Year) 1950

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: 12-16-1866

9. AGE last birthday: 83 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Wellersburg, Pa.

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Valentine Henckel

14. MOTHER'S MAIDEN NAME: Catherine Snyder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Lawrence Henckel, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X **Immediate cause** (a) Cerebral Hemorrhage — Interval between onset and death: 2 wk

**Antecedent cause(s)**

83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension — 1 yr.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1950, to Oct 4, 1950, that I last saw the deceased alive on Sept 30, 1950, and that death occurred at 3:15 P.M., from the causes and on the date stated above.

SIGNATURE: Wm Lane MD (Degree or title) ADDRESS: Frostburg Md DATE SIGNED: 10-4-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 10-6-1950 — NAME OF CEMETERY OR CREMATORY: St. Patrick's Cemetery — LOCATION (City, town, or county) (State): Mt. Savage, Md.

DATE REC'D BY LOCAL REG. 10-6-50 — REGISTRAR'S SIGNATURE: Mrs. Nancy V. Poe

24. FUNERAL DIRECTOR: J. R. Durst, — ADDRESS: Frostburg, Md.

RECEIVED
OCT 9 1950
BUREAU T. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09835

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland,
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 808 Greene St.,

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 808 Greene St.,

3. NAME OF DECEASED (Type or Print): (First) RUTH (Middle) SCOTT (Last) HENRY

4. DATE OF DEATH (Month) Oct. (Day) 27, (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married

8. DATE OF BIRTH: Oct. 9, 1879

9. AGE last birthday: 71 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (State or foreign country): Petersburg, Penna.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Cyrus Scott

14. MOTHER'S MAIDEN NAME: Caroline Rudy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Dr. R. A. Henry Cumb. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Apoplexy | 3 days |
| 334X 97 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Cerebral Sclerosis | 2 years |
| | (c) Generalized arteriosclerosis | 2 years |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-22, 1950, to 10-27, 1950, that I last saw the deceased alive on 10-26, 1950, and that death occurred at 8:45 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Ralph W. Ballin, M.D. 62 Greene St. Cumberland, Md 10-27-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: Oct. 30, 1950 | NAME OF CEMETERY OR CREMATORY: Cedar Grove | LOCATION (City, town, or county) (State): Petersburg, Penna.

DATE REC'D BY LOCAL REG.: Oct. 28, 1950 | REGISTRAR'S SIGNATURE: Hunter A. Trantz, M.D. | 24. FUNERAL DIRECTOR: H. Wayne George ADDRESS: Cumberland, Md.

RECEIVED
OCT 31 1950
BUREAU V. S

Within corporate limits

DR. DYER

**MARYLAND STATE DEPARTMENT OF HEALTH**

09836

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY: ALLEGANY; STATE: MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: MARYLAND; COUNTY: ALLEGANY |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND; LENGTH OF STAY (in this place): 9HRS. | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland (If rural, give location) |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL | STREET ADDRESS: R.F.D. RT# 4 Flintstone, Md |

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| MARY | Inez | HOFFMAN | OCT. | 9 | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
|---|---|---|---|---|---|---|
| FEMALE | WHITE | MARRIED | JUNE 25 1901 | 49 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| HOUSEWIFE | Own home | W.VA. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| WILLIAM LEVI Levi Williams | SUSAN WAYCHOFF |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| No | None | Miss Naomi F. Hoffman Cumberland Md |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 433.1 Immediate cause | (a) Cardiac decompensation | 3 days |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 95C | (b) Coronary fibrillation | Same |
| | (c) | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | None Known | |

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐ |
|---|---|---|
| | | |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from 10-8, 1950, to 10-9, 1950 that I last saw the deceased alive on 10-8, 1950 and that death occurred at 7:25 A.m., from the causes and on the date stated above.

| SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|
| John A. Dyer, M.D. | 247 Baltimore | 10-9-50 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/11/50 | Mt. Herman Cemetery | Cumberland, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 10, 1950 | Walter R. Frantz, M.D. | James F. Scarpelli | Cumberland, Md |

RECEIVED
OCT 18 1950
BUREAU F. B

MARYLAND STATE DEPARTMENT OF HEALTH

09837

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sylvan Retreat

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland
STREET ADDRESS (If rural, give location) R.D.# 2

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Thomas | Boyd | Hoffman | 10 | 31 | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months. | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | W | 6-4-61 | 89 yrs. | | | | |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Farm Hand
11. BIRTHPLACE (State or foreign country): Cumberland, Md
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George M. Hoffman
14. MOTHER'S MAIDEN NAME: Sarah Elizabeth Beall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT AND ADDRESS: Harold Valentine Cumberland, Md.

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Myocardial failure | 3 days |
| Antecedent cause(s) | | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Coronary sclerosis | 2 yrs |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

4/20/1 94a

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☑ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from Dec, 1946, to Oct. 31, 1950, that I last saw the deceased alive on Oct. 30, 1950, and that death occurred at 5:45 a m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Arthur F. Jones | M.D. | 110 S. Centre St. | Oct. 31 1950 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-2-1950 | Mt. Pleasant em. | Cumberland, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 11 2 50 | D. R. Trautz M.D | Charles L. George | Cumberland, Md. |

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NOV 7 1950
BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH

09838

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany | MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (In this place) 40 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland | COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 502 Pennsylvania Ave

3. NAME OF DECEASED (Type or Print): (First) Marie (Middle) (Last) Hudson

4. DATE OF DEATH: (Month) Oct (Day) 31 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Write): Widowed

8. DATE OF BIRTH: Sept 21, 1880

9. AGE last birthday: 70 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: at Home

11. BIRTHPLACE (State or foreign country): Washington Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Brady

14. MOTHER'S MAIDEN NAME: Susan Craig

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT AND ADDRESS: Chas L Brady Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Acute Coronary Insuf. | 3 hrs |
| 443X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d | (b) Hypertension C.V. Disease | Unknown |
| | (c) Uremia | Unknown |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 30, 19 50, to Oct 31, 19 50, that I last saw the deceased alive on Oct 30, 19 50, and that death occurred at 11:15 A m., from the causes and on the date stated above.

SIGNATURE — (Degree or title) ADDRESS DATE SIGNED

Wood T Reese MD. 404 Baltimore St Cumberland Md 11/4

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF Nov 4, 50 | NAME OF CEMETERY OR CREMATORY Catalpa Cem. | LOCATION (City, town, or county) (State) Cohill, Wash Co. Md.

DATE REC'D BY LOCAL REG. Nov. 4 1950 | REGISTRAR'S SIGNATURE Hunter R. Hartz, M.D. | 24. FUNERAL DIRECTOR Louis Stein | ADDRESS Cumberland

RECEIVED
NOV 17 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

09839

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH**
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place): MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 87 Spring St.

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 87 Spring St.

**3. NAME OF DECEASED** (Type or Print): (First) SARAH (Middle) ELLEN (Last) HUGHES

**4. DATE OF DEATH**: (Month) Oct. (Day) 20, (Year) 1950

**5. SEX**: female

**6. COLOR OR RACE**: white

**7. SINGLE, MARRIED, WIDOWED, DIVORCED** (Specify): single

**8. DATE OF BIRTH**: 10-10-1872

**9. AGE** last birthday: 78 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): housework

**10b. KIND OF BUSINESS OR INDUSTRY**: home

**11. BIRTHPLACE** (State or foreign country): Maryland

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: Robert Hughes

**14. MOTHER'S MAIDEN NAME**: Mary Shields

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If year, give war or dates of service):

**16. SOCIAL SECURITY NO.**: none

**17. INFORMANT AND ADDRESS**: Mary McAllister, Frostburg, Md.

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Cerebral Hemorrhage | 2 hours |
| Antecedent cause(s) | | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Rheumatic heart disease. | 1 yr. |
| | (c) Carcinoma of breast (rt) | 1 yr. |

170X
50

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Cerebral Hemorrhage with Hemiplegia — 6 months

**19a. DATE OF OPERATION**

**19b. MAJOR FINDINGS OF OPERATION**

**20. AUTOPSY?** Yes ☐ No ☐

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

**22.** I hereby certify that I attended the deceased from Oct. 5, 1950, to Oct. 20, 1950, that I last saw the deceased alive on Oct. 19, 1950, and that death occurred at 8:30 A m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| W. D. Gatters | M.D | Frostburg, Md | 10/21/50. |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-23-50 | St. Michaels Cemetery | Frostburg, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 10-22-50 | Mrs. Laney N. Poe | J. R. Durst, | Frostburg, Md. |

52086

RECEIVED
OCT 23 1950
BUREAU V. S

Within corporate limits DR. DYER

09840

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 8½ HOURS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE WEST VIRGINIA COUNTY Mineral
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN PATTERSON CREEK
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) JOSIE (Middle) JUDY (Last)

4. DATE OF DEATH (Month) OCT. (Day) 18, (Year) 1950

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED
8. DATE OF BIRTH MARCH 17, 1912
9. AGE last birthday 38 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME MARCELLUS BENNETT
14. MOTHER'S MAIDEN NAME MARGARET LAMBERT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL -CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| 442X Immediate cause | (a) Cardiac Failure | 1 yr. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 131a | (b) arteriosclerotic cardiovascular | 10 yrs. |
| | (c) renal disease | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-17, 1950, to ——, 19....., that I last saw the deceased alive on 10-17, 1950 and that death occurred at 1:55 Am., from the causes and on the date stated above.

SIGNATURE John A. Dyer, M.D. (Degree or title) ADDRESS 247 Va Ave DATE SIGNED 10-18-50

23. BURIAL, CREMATION REMOVAL (Specify) Removal & Burial
DATE THEREOF Oct. 20 1950
NAME OF CEMETERY OR CREMATORY Bland Family Cemetery
LOCATION (City, town, or county) Circleville (State) W.Va

DATE REC'D BY LOCAL REG. Oct. 18, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR F. R. Brown, ADDRESS Franklin, W.Va

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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OCT 24 1950
BUREAU V. S

Within corporate limits: Yes

MARYLAND STATE DEPARTMENT OF HEALTH

09841

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 28yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE West Virginia; COUNTY Mineral; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Wiley Ford; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) S. (Last) Kesner

4. DATE OF DEATH: (Month) (Day) (Year) 10/19/50 19

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 1/24/1882

9. AGE last birthday: 68 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Trucker

10b. KIND OF BUSINESS OR INDUSTRY: Coal

11. BIRTHPLACE (State or foreign country): Pendleton County, W.Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Soloman Kesner

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Elsie O. Kesner, Wiley Ford, W. Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Hemorrhage of The Brain | 10 minutes |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Arteriosclerosis and Hypertension 420.0 | 5 yrs. |
| | (c) arteriosclerotic and Hypertensive Heart Disease 93d | 6 mos. |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Thrombophlebitis right femur of twenty | 1 mo.

19a. DATE OF OPERATION: Sept 24, 1950

19b. MAJOR FINDINGS OF OPERATION: Lumbar Sympathetic block — no findings

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): No

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE): No

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: No

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? No

22. I hereby certify that I attended the deceased from Sept 21, 1950, to Oct 19, 1950, that I last saw the deceased alive on Oct 18, 1950, and that death occurred at 6:10 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Saville G Wiseman MD ADDRESS: 59 Greene St Cumberland Md DATE SIGNED: Oct 19, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE: 10/22/50 NAME OF CEMETERY OR CREMATORY: Rodeheaven Cem. LOCATION (City, town, or county) (State): Oakland, Md.

DATE REC'D BY LOCAL REG.: Oct. 20, 1950 REGISTRAR'S SIGNATURE: Hunter R Crantz MD

24. FUNERAL DIRECTOR: James F. Scarpelli ADDRESS: Cumberland, Md

42099

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OCT 24 1950
BUREAU V. S

DR. DYER

Within corporate limits

09842

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully.

I

VS. A15

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY: ALLEGANY; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND; LENGTH OF STAY (In this place): 3 DAYS; HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: MARYLAND; COUNTY: ALLEGANY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND; STREET ADDRESS (If rural, give location): 435 VIRGINIA AVE. |
| 3. NAME OF DECEASED (Type or Print): (First) CHARLES (Middle) H (Last) KEYS | 4. DATE OF DEATH: (Month) OCT. (Day) 19 (Year) 19 50 |
| 5. SEX: MALE | 6. COLOR OR RACE: WHITE |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED | 8. DATE OF BIRTH: FEB. 4 1887 |
| 9. AGE last birthday: 63 yrs. | If under 1 year: Months / Days; If under 24 hrs.: Hours / Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Restaurant Owner | 10b. KIND OF BUSINESS OR INDUSTRY: Owner |
| 11. BIRTHPLACE (State or foreign country): W.VA. Keyser | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME: JOSEPH KEYS | 14. MOTHER'S MAIDEN NAME: Mattie Fletcher |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWI 1917 | 16. SOCIAL SECURITY No.: 235-12-3653 |
| 17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL CUMBERLAND, MD. | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Coronary Occlusion | 3 days |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Arteriosclerotic heart disease | 1 yr. |
| | (c) | |

420.0 93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐ |
|---|---|---|

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? | | |

22. I hereby certify that I attended the deceased from 10-17, 19 50, to 10-19, 19 50, that I last saw the deceased alive on 10-19, 19 50, and that death occurred at 8:13 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John A. Dyer M.D. 247 Va ave 10-20-50

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/23/50 | Hillcrest Burial Park | Cumberland, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| Oct 20, 1950 | Hunter R Wantz, M.D. | James F. Scarpelli Cumberland, Md |

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BUREAU V. S

09843

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport
LENGTH OF STAY (in this place) 60 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 235 Maryland Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport
STREET ADDRESS (If rural, give location) 235 Maryland Ave.

3. NAME OF DECEASED (Type or Print) (First) CLAUDE (Middle) (Last) KIGHT

4. DATE OF DEATH (Month) Oct. (Day) 18 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Sept. 29, 1890
9. AGE last birthday 60 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter
10b. KIND OF BUSINESS OR INDUSTRY Paper Mill
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Oliver Kight
14. MOTHER'S MAIDEN NAME Katherine Barricks

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO. 217-05-0505
17. INFORMANT Hazel Kight

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Lymphocytic Leukemia — INTERVAL BETWEEN ONSET AND DEATH 3 mo

204.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

74a (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sep, 1950, to Oct 18, 1950, that I last saw the deceased alive on Oct 18, 1950, and that death occurred at 2 40 p m., from the causes and on the date stated above.

SIGNATURE James H. Wharton (Degree or title) Jr MD ADDRESS Richmond W. Va DATE SIGNED 10-21-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Oct. 21, 1950
NAME OF CEMETERY OR CREMATORY Philos
LOCATION (City, town, or county) Westernport (State) Md.

DATE REC'D BY LOCAL REG. 10/21/50
REGISTRAR'S SIGNATURE A. Gaynbaker M.D.
24. FUNERAL DIRECTOR E.S. Boal ADDRESS Westernport, Md.

34013

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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BUREAU V. S

Within corporate limits

Louis Bring?

The correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09844

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH**
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 2 weeks
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: W. Va — COUNTY: Allegany Mineral
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ft. Ashby
STREET ADDRESS (If rural, give location):

**3. NAME OF DECEASED** (Type or Print): (First) Samuel (Middle) McCoole (Last) Kuykendall

**4. DATE OF DEATH**: (Month) Oct (Day) 18 (Year) 1950

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months. | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | Married | Sept 18, 1877 | 73 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Farmer | Own farm | W. Va | USA |

**13. FATHER'S NAME**: Isaac Kuykendall

**14. MOTHER'S MAIDEN NAME**: Lucy Davis

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|---|
| No | | None | Mrs. Anna Kuykendall, Ft. Ashby, W. Va. |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) acute coronary occlusion | 1/2 hr |
| 420.0 Antecedent cause(s) | | |
| 93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) arteriosclerotic heart disease | 2 yrs |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from 9-8, 1950, to 10-18, 1950, that I last saw the deceased alive on 10-18, 1950, and that death occurred at 9:30 P.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| [signature] | (MD) | 59 Queen St. Cumberland Md | 10-18-50 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 20, 1950 | Indian Mound Cemetery | Romney, W. Va. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 18, 1950 | Walter L. Frantz, M.D. | John J. Hafer, Cumberland, Md. | |

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Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

09845

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (In this place) 4 hrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) 434 Race St.

3. NAME OF DECEASED (Type or Print) (First) Lee (Middle) H. (Last) Lacey
4. DATE OF DEATH (Month) Oct. (Day) 23 (Year) 1950
5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower
8. DATE OF BIRTH Oct. 19-1880
9. AGE last birthday 70 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired carpenter
10b. KIND OF BUSINESS OR INDUSTRY building
11. BIRTHPLACE (State or foreign country) Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME -- Anthony Lacey
14. MOTHER'S MAIDEN NAME -- Gentla A. Frey
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 220-10-9181
17. INFORMANT Mrs Ina Suesse (niece)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| 451x | Immediate cause | (a) Rupture of a arteriosclerotic aneurysm | about 6 |
| 96 | Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) of the abdominal aorta. | hours |
| | | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H. V. Deming M.D. ADDRESS Cumberland, Md. DATE SIGNED Oct. 23-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Oct. 26, 1950
NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
LOCATION (City, town, or county) Cumberland, (State) Md.

DATE REC'D BY LOCAL REG. Oct. 26, 1950
REGISTRAR'S SIGNATURE Winter K. Frantz, M.D.
24. FUNERAL DIRECTOR John J. Hofer, ADDRESS Cumberland, Md.

308 V

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

09846

Reg. Dist. No. 9

| | |
|---|---|
| 1. PLACE OF DEATH COUNTY: Allegany MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Maryland COUNTY: Alllegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg — LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eckhart |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital | STREET ADDRESS (If rural, give location) |

| | | | | | |
|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) MATILDA | (Middle) MAY | (Last) LEWIS | 4. DATE OF DEATH | (Month) Oct. (Day) 2, (Year) 1950 |
| 5. SEX: female | 6. COLOR OR RACE: white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed | 8. DATE OF BIRTH: 10-8-1879 | 9. AGE last birthday: 70 yrs. | If under 1 year: Months, Days; If under 24 hrs.: Hours, Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife | 10b. KIND OF BUSINESS OR INDUSTRY: home | 11. BIRTHPLACE (State or foreign country): Maryland | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME: William Blank | 14. MOTHER'S MAIDEN NAME: Elizabeth Frank | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY No.: none | 17. INFORMANT AND ADDRESS: Irvin Lewis, Eckhart, Md. | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Coronary Occulsion — | 4 days. |
| Antecedent cause(s) | | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Arteriosclerosis | Year |
| | (c) | |

420.1

94a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION: — | 19b. MAJOR FINDINGS OF OPERATION: — | 20. AUTOPSY? Yes ☐ No ☒ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify): — | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): — | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? — |

22. I hereby certify that I attended the deceased from 30 Sept, 1950, to 2 Oct, 1950, that I last saw the deceased alive on 2 Oct, 1950, and that death occurred at 2:55 P.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| John B. Davis | M.D. | Frostburg, Md. | 10/3/50 |

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: 10-5-50 | NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park | LOCATION (City, town, or county) (State): Cumberland, Md. |
| DATE REC'D BY LOCAL REG.: 10-5-50 | REGISTRAR'S SIGNATURE: Mrs Nancy H. Roe | 24. FUNERAL DIRECTOR: J. R. Durst, | ADDRESS: Frostburg, Md. |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

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VS. A15

RECEIVED
OCT 9 1950
BUREAU V. S

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

09847

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: rural Cumberland; MARYLAND; LENGTH OF STAY (In this place): 12 yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Box 394 R.F.D.#1 Mt Savage Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland (rural); STREET ADDRESS (If rural give location): R.F.D.1 Mt.Savage Rd. Box 394

3. NAME OF DECEASED (Type or Print): (First) Jesse (Middle) Elbert (Last) Logsdon

4. DATE OF DEATH: (Month) Oct. (Day) 21 (Year) 1950

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: April 30-1905

9. AGE last birthday: 45 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: --Zimmerly Paint & Body Shop

11. BIRTHPLACE (State or foreign country): Hyndman, Pa.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Lewis Logsdon

14. MOTHER'S MAIDEN NAME: Elanor Pleasant Mason

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): W.W.2

16. SOCIAL SECURITY NO.: 214-05-5423

17. INFORMANT: Wife-

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Coronary occlusion | at once |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Coronary sclerosis | ? |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V.Deming M.D. H. V. Deming M.D. Cumberland, Md. Oct.21-1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE THEREOF: Oct. 25, 1950; NAME OF CEMETERY OR CREMATORY: Cooks Mill Cemetery; LOCATION (City, town, or county) (State): Near Hyndman Texas

DATE REC'D BY LOCAL REG.: Oct. 23, 1950; REGISTRAR'S SIGNATURE: Walter L. Bantz, M.D.; 24. FUNERAL DIRECTOR: John J. Hafer; ADDRESS: Cumberland, Md.

VS. A15A

3409

RECEIVED
NOV 1 1950
BUREAU V. S

DR. TOLSON 1454

09848

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 28 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE WEST VIRGINIA COUNTY Mineral
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN PATTERSON CREEK
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) BLAINE (Middle) A. (Last) McCULLOUGH
4. DATE OF DEATH (Month) OCT. (Day) 26 (Year) 1950
5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED
8. DATE OF BIRTH MAY 22 1878
9. AGE last birthday 72 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Telegrapher
10b. KIND OF BUSINESS OR INDUSTRY B. & O. RR
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME WILLIAM HAMILTON McCULLOUGH
14. MOTHER'S MAIDEN NAME ELIZABETH ROCKWELL
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY No. 705 05 9874
17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL, MEMORIAL AVE.,

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Benign hypertrophy prostate — 2 years

610X

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

137a

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Surgical shock, arteriosclerosis

19a. DATE OF OPERATION 10-26-50
19b. MAJOR FINDINGS OF OPERATION Enlarged obstructing prostate
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-28-, 1950 to 10-26, 1950, that I last saw the deceased alive on 10-26, 1950, and that death occurred at 5:55P m., from the causes and on the date stated above.

SIGNATURE Howard L. Tolson, M.D. (Degree or title) ADDRESS DATE SIGNED 10-27-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Oct 29 1950
NAME OF CEMETERY OR CREMATORY Ft. Ashby Cemetery
LOCATION (City, town, or county) Ft. Ashby, (State) W. Va.

DATE REC'D BY LOCAL REG. Oct. 28, 1950
REGISTRAR'S SIGNATURE Winter R. Trantz, M.D.
24. FUNERAL DIRECTOR William H. Kight ADDRESS Cumberland, Md.

24047

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 31 1950
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

09849

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport — LENGTH OF STAY (In this place) 25 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport
STREET ADDRESS (If rural give location) Riordian Road

3. NAME OF DECEASED (Type or Print): (First) Robert Emmitt (Middle) (Last) McGreevy

4. DATE OF DEATH: (Month) Oct. (Day) 8 (Year) 1950 19

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Sept. 7 1903

9. AGE last birthday: 47 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: General

11. BIRTHPLACE (State or foreign country): Barton, Md

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Michael McGreevy

14. MOTHER'S MAIDEN NAME: Anna Footen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW #2

16. SOCIAL SECURITY NO.: 215-26-2243

17. INFORMANT: John McGreevy Westernport, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Coronary Occulusion | At once |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | |
| | (c) | |

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

H.V. Deming M.D. H. V. Deming M.D. Cumberland, Md Oct. 1, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Oct. 10, 1950 — NAME OF CEMETERY OR CREMATORY: Philos Cemetery — LOCATION (City, town, or county) (State): Westernport, Md.

DATE REC'D BY LOCAL REG. Oct. 10/50 — REGISTRAR'S SIGNATURE: Gladys Mabe MD — 24. FUNERAL DIRECTOR: W. Harold Fredbrk Jr — ADDRESS: Piedmont, W. Va.

98899

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OCT 19
BUREA

Outside of City Limits

09850

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Cumberland — LENGTH OF STAY (in this place): 25 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: La Vale

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland (Rural)
STREET ADDRESS (If rural, give location): La Vale Rt 40 W.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Margaret Irene Metty
4. DATE OF DEATH (Month) (Day) (Year): Oct 2 1950
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: May 30 1900
9. AGE last birthday: 50 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: at Home
11. BIRTHPLACE (State or foreign country): Lonaconing Md
12. CITIZEN OF WHAT COUNTRY: USA
13. FATHER'S NAME: James D. Peebles
14. MOTHER'S MAIDEN NAME: Lucy Corfield
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Howard D Metty, La Vale

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 Immediate cause (a) Pulmonary Infarction — 1 day

93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive & Coronary Heart disease — ?

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. ~~Pulmonary~~ Coronary Thrombosis with Infarction — 2 months

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12 Aug, 1950, to 2 Oct., 1950, that I last saw the deceased alive on 30 Sept, 1950, and that death occurred at 2 30 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
W. Alfred Van Ormer, Cumberland, Md — 2 Oct. 50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Oct 4 1950 — NAME OF CEMETERY OR CREMATORY: Hillcrest Cem — LOCATION (City, town, or county) (State): Cumberland Md
DATE REC'D BY LOCAL REG.: Oct. 3, 1950 — REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D. — 24. FUNERAL DIRECTOR: Louis Stein Inc — ADDRESS: Cumberland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 10 1950
BUREAU V. S

Within corporate limits Dr. Tolson

09851

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD.
LENGTH OF STAY (in this place) 11 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE PENNSYLVANIA COUNTY Somerset
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN GLENCOE
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) HARVEY (Middle) (Last) MEYERS
4. DATE OF DEATH (Month) OCT. (Day) 25 (Year) 1950
5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED
8. DATE OF BIRTH AUG. 13 1880
9. AGE last birthday 70 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Own farm
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JACKSON MEYERS
14. MOTHER'S MAIDEN NAME ELLEN POORBAUGH
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 198-20-4077
17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma Prostate — INTERVAL BETWEEN ONSET AND DEATH 8-9 years

177X

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

51b

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-14, 1950, to 10-25, 1950, that I last saw the deceased alive on 10-25, 1950, and that death occurred at 8 P.m., from the causes and on the date stated above.

SIGNATURE Howard L. Tolson MD (Degree or title) ADDRESS Cumberland, Md DATE SIGNED 10-26-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Oct. 28, 1950
NAME OF CEMETERY OR CREMATORY Mt Tabanon Cemetery
LOCATION (City, town, or county) R.D. Glencoe, Pa (State)

DATE REC'D BY LOCAL REG. Oct. 27, 1950
REGISTRAR'S SIGNATURE Write R. Hantz, M.D.
24. FUNERAL DIRECTOR Johnson & Son ADDRESS Berlin Pa

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
OCT 31 1950
BUREAU OF S

09853

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 6

**1. PLACE OF DEATH:**

County: Allegany

City or town: Westernport.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Fifty years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Westernport.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 146 Church
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME**

Chritine Catharine Miller.

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6.(b) Name of husband or wife: John P. Miller

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 6, 1874.

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 6 | 14 | ..... hrs. ..... min. |

9. Birthplace: Accident, Garrett, Maryland.
(Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business: 170X

FATHER
12. Name: John L. Richter.
13. Birthplace: Germany,

MOTHER
14. Maiden name: Catharine Schneider.
15. Birthplace: Accident, Maryland.

16. Informant: Miss Leola Richter,
Address: Pittsburg, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 22, 1950 (month) (day) (year)

Cemetery or ~~crematory~~ xxxx Accident, Md.

Location: Accident, Garrett Co. Md.

18. Funeral director: W. Harold Friedlich Jr
Address: Piedmont Wva

19. Oct. 22 1950 (Date rec'd by registrar) A. Gaynbaker MD Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: October 20, 1950 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 1950 to Oct 20 1950 and that I last saw her alive on Oct 20 1950

| Immediate cause of death | DURATION |
|---|---|
| Congestive Heart Failure | |
| Due to Hypertensive cardiovascular disease | 4 yrs |
| Due to 443X | |
| Other conditions Carcinoma Rt breast 50 | 3 yrs |

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: James H. Wolverton Jr MD
M. D. or other

Address: Piedmont W. Va Date signed: 10-21-50

VS A15 9-45-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

MARGIN RESERVED FOR BINDING

170X

RECEIVED
OCT 30 1950
BUREAU V. S

Within corporate limits

Dr Weisman

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09852

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (In this place) 10 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Pa COUNTY Bedford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bedford
STREET ADDRESS (If rural, give location) Route 3 ✓

3. NAME OF DECEASED (Type or Print) (First) Cora (Middle) Martha (Last) Miller

4. DATE OF DEATH (Month) Oct (Day) 14 (Year) 1950

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH Sept 23, 1868

9. AGE last birthday 82 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Bedford Valley Pa

12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME Thomas Elliott

14. MOTHER'S MAIDEN NAME Elmira Boor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Mrs Myrtle Christman, Cumb Rt 3.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Heart failure, Acute | 3 weeks |
| Antecedent cause(s) | (b) Bronchitis | 3 weeks |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (c) Hypertensive and Arteriosclerotic heart disease | 5 weeks |

420.0

93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1948, to Oct 14, 1950, that I last saw the deceased alive on Oct 14, 1950, and that death occurred at 6 55 P.m., from the causes and on the date stated above.

SIGNATURE Saville G Weisman Mrs (Degree or title) 59 Greene St ADDRESS Cumberland, Md DATE SIGNED Oct 17, 1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE Oct 17, 1950

NAME OF CEMETERY OR CREMATORY Fellowship Cemetery

LOCATION (City, town, or county) Centerville (State) Pa.

DATE REC'D BY LOCAL REG. Oct. 17, 1950

REGISTRAR'S SIGNATURE Winter R. Lantz, M.D.

24. FUNERAL DIRECTOR John J Hafer ADDRESS Cumberland Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

RECEIVED
OCT 24 1950
BUREAU F. S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09854

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 75 yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS 306 Harrison St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 306 Harrison St.

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Missouri | Alice | Murray | Oct | 7 | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Mln. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Widowed | June 6 1869 | 81 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At Home | Somerset Penna | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Jacob Mantz | Sarah Boemaker |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS. |
|---|---|---|
| No | None | Mrs Geraldine Smithers, Cumberland |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 422.1 Immediate cause | (a) Chronic Myocarditis | 3 years |
| 93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Arteriosclerosis | 2½ " |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐ |
|---|---|---|
| | | |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from Jan 1, 1950, to Oct 7, 1950, that I last saw the deceased alive on Oct 7, 1950, and that death occurred at 6:30 P.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| R.W. Trevaskis, Jr | | Cumberland, Maryland | Oct 9-1950 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | Oct 10 1950 | Odd Fellows Cem. | Salisbury | Penna |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 9, 1950 | Hunter A. Mantz, M.D. | Louis Stein, Inc., | Cumberland |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 18 1960
BUREAU V. S

Outside of City Limits

# MARYLAND STATE DEPARTMENT OF HEALTH

09855

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN R. D. #1 La Vale
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS R. D. #1 La vale

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural La Vale
STREET ADDRESS (If rural, give location) R. D. #1

3. NAME OF DECEASED (Type or Print): (First) Marcellus (Middle) C. (Last) Ours

4. DATE OF DEATH: (Month) Oct. (Day) 23, (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Oct. 13, 1874

9. AGE last birthday: 76 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Self employed

11. BIRTHPLACE (State or foreign country): Petersburg, W. Va.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: James Ours

14. MOTHER'S MAIDEN NAME: Rebecca Dolly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs. Nina Bramble R. D. #1 La Vale

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) generalized arteriosclerosis — 5 yrs

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

I50.0
97

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-2, 19 45, to 10-23, 19 50, that I last saw the deceased alive on 10-22, 19 50, and that death occurred at 1:00 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

[signature] M.D. 516 Green St. 10-23-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Oct. 25, 1950
NAME OF CEMETERY OR CREMATORY: Ours Family Cemetery
LOCATION (City, town, or county) (State): Grant County, West Virginia

DATE REC'D BY LOCAL REG.: Oct. 23, 1950
REGISTRAR'S SIGNATURE: Winter R. Fantz, M.D.
24. FUNERAL DIRECTOR: H. Wayne George
ADDRESS: Cumberland, Md.

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 1 1950
BUREAU OF S

Within corporate limits DR. SIMONS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09857

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 4 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE NORTH CAROLINA COUNTY Cake
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RAEFORD
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Baby (Middle) Boy #1 (Last) PETERSON

4. DATE OF DEATH (Month) OCTOBER (Day) 7 (Year) 1950

5. SEX MALE

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE

8. DATE OF BIRTH OCT. 3 1950

9. AGE last birthday yrs. If under 1 year Months Days 4 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME FRED D. PETERSON

14. MOTHER'S MAIDEN NAME MELBA L. WILSON

15. WAS DECEASED EVER IN U.S. ARMED FORCE? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. None

17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Atelectasis — 4 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Prematurity (3 o weeks)

762.5
159

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 3, 1950, to Oct 7, 1950, that I last saw the deceased alive on Oct 7, 1950, and that death occurred at 5:45 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

George M Brown M.D. Cumberland, Md October 8, 1950

23. BURIAL, CREMATION, REMOVAL (Specify) Cremation

DATE THEREOF Oct. 9, 1950

NAME OF CEMETERY OR CREMATORY Memorial Hospital

LOCATION (City, town, or county) (State) Cumberland, Maryland

DATE REC'D BY LOCAL REG. Oct. 9, 1950

REGISTRAR'S SIGNATURE Walter R. Tantz, M.D.

24. FUNERAL DIRECTOR Memorial Hosp.

ADDRESS Cumberland, Md.

2-1-0-07-0-23-1-30-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 18 1950
U.S. BUREAU

Within corporate limits: DR. SIMONS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09858

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, — LENGTH OF STAY (in this place) 1 DAY
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE NORTH CAROLINA — COUNTY Hoke
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RAEFORD
STREET ADDRESS (If rural, give location) ✓

3. NAME OF DECEASED (Type or Print): (First) PETERSON (Middle) BABY BOY #2 (Last) Larry Gene

4. DATE OF DEATH: (Month) OCT. (Day) 4 (Year) 1950

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE

8. DATE OF BIRTH: OCT. 3, 1950

9. AGE last birthday: ~~1DAY~~ yrs. — If under 1 year: Months — Days 1 — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: FRED PETERSON

14. MOTHER'S MAIDEN NAME: MELBA WILSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL CUMBERLAND, MD

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

774x Immediate cause (a) Cardiac insufficiency — Interval between onset and death: 2 hrs

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
159 (b) Premature (3 weeks)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 2, 19 5[illegible], to Oct 4, 19 5[illegible], that I last saw the deceased alive on Oct 4, 19 5[illegible], and that death occurred at 10:23 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

George Memorial M.D. Cumberland, Md. Oct 5 1950

23. BURIAL, CREMATION, REMOVAL (Specify): CREMATION — DATE THEREOF: 10-5-50 — NAME OF CEMETERY OR CREMATORY: MEMORIAL HOSPITAL — LOCATION (City, town, or county) (State): CUMBERLAND, MARYLAND

DATE REC'D BY LOCAL REG. Oct. 5, 1950 — REGISTRAR'S SIGNATURE: Walter L. Wantz, M.D. — 24. FUNERAL DIRECTOR: Memorial Hosp. — ADDRESS: Cumberland, Md.

2-1-0-03-0-23-2-30-1

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 10 1950
BUREAU V. S

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09859

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; LENGTH OF STAY (in this place): 12 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg; STREET ADDRESS (If rural, give location): 78 Mt. Pleasant Street

3. NAME OF DECEASED (Type or Print): (First) Glenrose (Middle) M. (Last) Porter

4. DATE OF DEATH: (Month) 10 (Day) 25 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: Aug. 1st, 1902

9. AGE last birthday: 48 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: St. Michael's Rectory

11. BIRTHPLACE (State or foreign country): Frostburg, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Gilbert Porter

14. MOTHER'S MAIDEN NAME: Alice Metzner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No.

16. SOCIAL SECURITY NO.: 214-05-5079

17. INFORMANT AND ADDRESS: Mrs. Alice Porter, 78 Mt. Pleasant St. Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

431X Immediate cause (a) Acute Myocarditis — Interval Between Onset and Death: 8 days

56b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Multiple myxoma of uterus with secondary 3 months

19a. DATE OF OPERATION: 10-18-50

19b. MAJOR FINDINGS OF OPERATION: multiple myxoma of uterus

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from October 1949 to October, 1950, that I last saw the deceased alive on October 27, 1950, and that death occurred at 5:55 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

[signature] M.D. Cumberland Md 10-26-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 10/28/50

NAME OF CEMETERY OR CREMATORY: St. Michael's Cemetery

LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG.: Oct. 27, 1950

REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR ADDRESS: Jacob Hafer 23 E. Main, Frostburg, Md

22257

RECEIVED
NOV 1 1960
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

09856

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland Oakland
STREET ADDRESS (If rural, give location): Memorial Hospital ✓

3. NAME OF DECEASED (Type or Print): (First) Richard (Middle) — (Last) Porter

4. DATE OF DEATH: (Month) Oct (Day) 29 (Year) 19 50

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: 4/28/50

9. AGE last birthday: 6 Months — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cumberland Md

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Prentiss Porter

14. MOTHER'S MAIDEN NAME: Betty M. Bittinger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Memorial Hospital, Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

344X **Immediate cause** (a) Cardiac failure

**Antecedent cause(s)** Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

157a (b) Hydro-cephalus.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19....., to 29 Oct, 19 50, that I last saw the deceased alive on 29 Oct, 19 50, and that death occurred at .....m., from the causes and on the date stated above.

SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED

R. S. Cooper M.D. — 101 S. Centre St. — 29 Oct 50.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: Oct 31 1950 | NAME OF CEMETERY OR CREMATORY: Oakland Cemetery | LOCATION (City, town, or county) (State): Oakland Md

DATE REC'D BY LOCAL REG. Oct. 29, 1950 | REGISTRAR'S SIGNATURE: Hunter A. Tantz, M.D. | 24. FUNERAL DIRECTOR | ADDRESS: Herbert Leighton, Oakland, Md

2-0-4-28-0-26-1-36-5 J

RECEIVED
OCT 31 1960
BUREAU T. S

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09860

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 21 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 55 Oak St.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 55 Oak St.

3. NAME OF DECEASED (Type or Print): (First) Earl (Middle) Edward (Last) Purinton

4. DATE OF DEATH (Month) (Day) (Year): October 21, 1950

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: October 20, 1871
9. AGE last birthday: 79 yrs. — If under 1 year: Months. Days — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Conductor
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): Independence, W.Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Francis Purinton
14. MOTHER'S MAIDEN NAME: Florence Howell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service): No
16. SOCIAL SECURITY NO.: 705-09-7790
17. INFORMANT AND ADDRESS: Agnes Purinton 55 Oak St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary occlusion — 1 hr

Antecedent cause(s)

420.1 93d

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Cardiovascular

(c) Disease — 1 yr.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct., 1949, to Oct 21, 1950, that I last saw the deceased alive on Oct. 21, 1950, and that death occurred at 8:15 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): John A. Dyer, M.D. — ADDRESS: 247 Va Ave — DATE SIGNED: 10-23-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 10/24/50 — NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Oct. 23, 1950 — REGISTRAR'S SIGNATURE: Walter R. Frantz, M.D.
24. FUNERAL DIRECTOR: James F. Scarpelli — ADDRESS: Cumberland, Md.

10247

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NOV 1 1950
BUREAU V. S

Outside of City Limits

09861

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: rural, near Cumberland
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: About midway between Allegany Grove & 6 Mile House, in woods

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural give location): East. Main St.

3. NAME OF DECEASED (Type or Print): (First) Lucian (Middle) Carl (Last) Radcliffe
4. DATE OF DEATH: (Month) Oct (Day) 19 (Year) 1950

5. SEX: Male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: Feb. 3-1895
9. AGE last birthday: 55 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired Tax collector
10b. KIND OF BUSINESS OR INDUSTRY: Allegany County, Md.
11. BIRTHPLACE (State or foreign country): Vale Summitt Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph Radcliffe
14. MOTHER'S MAIDEN NAME: Eva Belle Long

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Jonathan Radcliffe

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 976x Immediate cause | (a) Pulmonary & cerebral hemorrhage due to | at once |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. 164c | (b) 38 caliber revolver wounds. (suicide) | |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office, etc.): Off Highway route 49
near (CITY OR TOWN) Cumberland (COUNTY) Allegany (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour): Oct. 19/50-3 P.m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Shot himself

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): H. V. Deming M.D.
ADDRESS: Cumberland, Md.
DATE SIGNED: Oct 19-1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: 10/22/1950
NAME OF CEMETERY OR CREMATORY: Rose Hill Mausoleum
LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Oct. 22/50
REGISTRAR'S SIGNATURE: Walter L. Frantz, M.D.
24. FUNERAL DIRECTOR: William H. Kight, Cumberland, Md.
ADDRESS

VS. A15A

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BUREAU V. S

Dr. Davis

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09862

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH**
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 25 Bealls Lane

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| JOHN | HENRY | RANK | Oct. | 29, | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | single | 6-27-1873 | 77 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| retired miner | coal mines | Frostburg, Md. | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Louis Rank | Frederica Blonker |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| | 216-12-7188 | Mrs. Mary Fischer, Frostburg, Md. |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Cirhosis Liver – Biliary | appox 3 wks. |
| 581.0 Antecedent cause(s) | | |
| 1248 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from 1st Oct., 1950, to 29 October, 1950, that I last saw the deceased alive on 29 October, 1950, and that death occurred at 12 10 A.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| John B. Davis, M.D. | | Frostburg, Md. | 10/30/50. |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-31-1950 | Zion Evan. & Ref. Cem. | Frostburg, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 10-31-50 | Mrs. Nancy K Roe | J. R. Durst, | Frostburg, Md. |

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BUREAU V. L.

MARYLAND STATE DEPARTMENT OF HEALTH

09863

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. 415

1. PLACE OF DEATH: COUNTY Allegany MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 115 Hill Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; STREET ADDRESS (If rural, give location) 115 Hill street

3. NAME OF DECEASED (Type or Print): (First) CECIL (Middle) (Last) RODDA

4. DATE OF DEATH: (Month) Oct. (Day) 22, (Year) 19 50

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: 1-27-1900

9. AGE last birthday: 50 yrs. If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer

10b. KIND OF BUSINESS OR INDUSTRY: Brickyard

11. BIRTHPLACE (State or foreign country): Frostburg, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Rodda

14. MOTHER'S MAIDEN NAME: Minnie Udy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: 219-03-9516

17. INFORMANT AND ADDRESS: Robert Rodda, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis — Interval Between Onset and Death: Sudden

420.1 Antecedent cause(s) (b) Chr Myocarditis — 6 Mo

932 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1950, to Oct 22, 1950, that I last saw the deceased alive on Oct 13, 1950, and that death occurred at 2:00 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Wm C Lane MD

ADDRESS Frostburg Md

DATE SIGNED 10-24-50

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE 10-25-1950

NAME OF CEMETERY OR CREMATORY Fbg. Memorial Park

LOCATION (City, town, or county) (State) Frostburg, Md.

DATE REC'D BY LOCAL REG. 10-25-50

REGISTRAR'S SIGNATURE Mrs. Lawley A. Roe

24. FUNERAL DIRECTOR J. R. Durst, Frostburg, Md.

ADDRESS

960

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OCT 27 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

09864

Reg. Dist. No. 1

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural near Old Town, Md.
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Route 51

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Pa/ COUNTY Bedford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manns Choice
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Asa (Middle) Stuckey (Last) Sams
4. DATE OF DEATH (Month) Oct. (Day) 15 (Year) 1950
5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH Nov.11-1882
9. AGE last birthday 67 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Justice of the Peace
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Manns Choice, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Martin Sams
14. MOTHER'S MAIDEN NAME Susan Stuckey
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 161-12-6161
17. INFORMANT Mrs. Zora Sams

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

8165 Immediate cause (a) Pulmonary hemorrhage due to punctured lungs — at once

170c Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) from fractured ribs. (crushed chest)

(c) Fractured right leg below knee.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Automobile accident

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway Route 51 near (CITY OR TOWN) Old Town (COUNTY) Allegany (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) Oct.15/50 1.45 P. m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? A truck ran into opposite lane, & crashed headon with auto.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland, Md. DATE SIGNED Oct.16-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 10/18/50
NAME OF CEMETERY OR CREMATORY Bedford Memorial Park
LOCATION (City, town, or county) Bedford (State) Pa.
DATE REC'D BY LOCAL REG. Oct. 16, 1950
REGISTRAR'S SIGNATURE Mrs. Sue C. Gonevan
24. FUNERAL DIRECTOR James F. Scarzelli ADDRESS Cumberland Md.

11898

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
OCT 23 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

09865

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

**1. PLACE OF DEATH**
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
MARYLAND — LENGTH OF STAY (In this place): Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 619 N.Center St.

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 619 N.Center St.

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Henry | Raymond | Shertzer | Oct. | 19 | 19 50 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | single | Nov.1-1894 | 55 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Shipping clerk | Celanese Corp. | Cumberland, Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John Micheal Shertzer | Wilhelmina Gruber |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| no | 214-07-4741 | Mrs Shertzer (mother) |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Angina pectoris | at once |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Coronary sclerosis | ? |
| | (c) | |

420.1
940

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|
| H.V.Deming M.D. H.V. Deming M.D. | Cumberland,Md. | Oct.19-1950 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 22 '50 | St Lukes Cem | Cumberland Md |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 22, 1950 | Virgil R. Kantz, M.D. | Louis Stein Inc, | Cumberland Md |

226 16

RECEIVED
NOV 1 1950
BUREAU V. S

DR. FAW

09866

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 18 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE PENNSYLVANIA COUNTY W BEDFORD
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HYNDMAN
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) SOLOMON L. SHROYER
4. DATE OF DEATH (Month) (Day) (Year) 19 50 ✓
5. SEX MALE
6. COLOR OR RACE WHITW
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW
8. DATE OF BIRTH JULY 31, 1883
9. AGE last birthday 67 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal miner
10b. KIND OF BUSINESS OR INDUSTRY COAL MINER
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME NATHANIEL SHROYER
14. MOTHER'S MAIDEN NAME ELLEN SHAFFER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 219-03-9231
17. INFORMANT AND ADDRESS Walter Shroyer Hyndman, Pa.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Abdominal carcinomatosis primary lesion unknown with cachexia and ascites

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

199.1

55e

INTERVAL BETWEEN ONSET AND DEATH: One year

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 10, 1950, to Oct 28, 1950, that I last saw the deceased alive on Oct 28, 1950, and that death occurred at 9/24P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Sylvester M Faw Jr. M. D
ADDRESS Cumberland Md
DATE SIGNED Oct 29, 1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 10/31/1950
NAME OF CEMETERY OR CREMATORY Camps Cemetery
LOCATION (City, town, or county) (State) Hyndman, RD#1.
DATE REC'D BY LOCAL REG. Oct. 30, 1950
REGISTRAR'S SIGNATURE Winter R Frantz M.D.
24. FUNERAL DIRECTOR Harvey H. Leigler
ADDRESS Hyndman Pa.

45 [illegible]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 31 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09867

# CERTIFICATE OF DEATH

Reg. Dist. No. 9

| | |
|---|---|
| 1. PLACE OF DEATH · COUNTY: Allegany MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg — LENGTH OF STAY (in this place): | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS: 115 Mt. Pleasant St. | STREET ADDRESS (If rural, give location): 115 Mt. Pleasant St. |

| | | | | | |
|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) HELEN | (Middle) VERONICA | (Last) SLEEMAN | 4. DATE OF DEATH | (Month) Oct. (Day) 8, (Year) 1950 |
| 5. SEX: female | 6. COLOR OR RACE: white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed | 8. DATE OF BIRTH: 2-26-1879 | 9. AGE last birthday: 71 yrs. | If under 1 year: Months / Days; If under 24 hrs.: Hours / Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework | 10b. KIND OF BUSINESS OR INDUSTRY: home | 11. BIRTHPLACE (State or foreign country): Vale Summit, Md. | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME: John Flanagan | 14. MOTHER'S MAIDEN NAME: Margaret Friel | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO.: None | 17. INFORMANT AND ADDRESS: Veronica Sleeman, Frostburg, Md. | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinoma of Stomach with Metastasis — 10 months

151X Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

46 b (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION: February 1950 | 19b. MAJOR FINDINGS OF OPERATION: Carcinoma of Stomach | 20. AUTOPSY? Yes ☐ No ☒ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE) | |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from December 1949, to 10-9, 1950, that I last saw the deceased alive on 10-7, 1950 and that death occurred at 10 A m., from the causes and on the date stated above.

SIGNATURE: J. E. Johnson Jr. (Degree or title) M.D. — ADDRESS: Cumberland Md — DATE SIGNED: 10-10-50

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: 10-11-50 | NAME OF CEMETERY OR CREMATORY: St. Michaels Cemetery | LOCATION (City, town, or county) (State): Frostburg, Md. |
| DATE REG'D BY LOCAL REG.: 10-11-50 | REGISTRAR'S SIGNATURE: Mrs. Nancy H. Roe | 24. FUNERAL DIRECTOR: J. R. Durst, Frostburg, Md. | ADDRESS |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 16 1950
BUREAU

Within corporate limits DR. ROBINSON

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09868

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD. LENGTH OF STAY (in this place) 1 HR. 35MIN.
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN LONACONING, MD.
STREET ADDRESS (If rural, give location) 106 W. MAIN STREET

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| JAMES | EARL | SMITH | OCT. | 26, | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | SINGLE | 10/23/50 | yrs. | 3 DAYS | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | MARYLAND | USA. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| JOHN S. SMITH JR. | SHIRLEY NIGHTINGALE |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| No | None | MEMORIAL HOSPITAL - CUMBERLAND, MD. |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Sclerema

773.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

161c (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from 10/25, 1950, to 10/26, 1950, that I last saw the deceased alive on 10/26, 1950, and that death occurred at 1:20 A m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Thomas Robinson | M.D. | 19 S. Liberty St. Cumberland, Md | 10/26/50 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 26 1950 | Oak Hill Cemetery | Lonaconing, Maryland |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 26, 1950 | Walter L. Kantz, M.D. | M. Eichhorn, Lonaconing, Maryland | |

2-0-0-23-0-18-1-31-4

VS. A15

RECEIVED
NOV 1 1950
BUREAU V. S

Within corporate limits

09869

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 3 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS 910 Bedford St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE ~~Md~~ Pa. COUNTY Bedford ~~Allegany~~
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Black Valley
STREET ADDRESS (If rural, give location) Rural - Flintstone, Md. ✓

3. NAME OF DECEASED (Type or Print) (First) Nathan (Middle) R (Last) Smith
4. DATE OF DEATH (Month) Oct (Day) 20 (Year) 1950

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH July 26, 1857
9. AGE last birthday 93 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Own farm
11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Jasper Smith
14. MOTHER'S MAIDEN NAME Mary Ann Elbin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT Ira Smith, 910 Bedford St., Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| Immediate cause | (a) | Coronary occlusion | 12 hours |
| 420.1 Antecedent cause(s) | (b) | Arteriosclerosis | 5 years |
| 94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (c) | Senility | 10 years |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 9, 1950, to Oct 20, 1950, that I last saw the deceased alive on Oct 20, 1950, and that death occurred at 9 A. m., from the causes and on the date stated above.

SIGNATURE R. W. Trevaskis, Sr (Degree or title) ADDRESS Cumberland Maryland DATE SIGNED 10/20/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 10/22/50
NAME OF CEMETERY OR CREMATORY Prosperity Christian
LOCATION (City, town, or county) Bedford Co. (State) Pa.

DATE REC'D BY LOCAL REG. Oct. 22, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR John J. Hofer, Cumberland, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 1 1958
BUREAU U. S

M

C

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09870

# CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 30 min.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Alleg.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg.
STREET ADDRESS (If rural give location) 121 Bowery St.

3. NAME OF DECEASED (Type or Print) (First) John (Middle) Jefferson (Last) Steele

4. DATE OF DEATH (Month) 10 (Day) 28 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH 10-28-50
9. AGE last birthday 0 yrs. If under 1 year Months — Days — If under 24 hrs. Hours — Min. 30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant
10b. KIND OF BUSINESS OR INDUSTRY Infant
11. BIRTHPLACE (State or foreign country) Frostburg, Md
12. CITIZEN OF WHAT COUNTRY? N.S.

13. FATHER'S NAME Ralph A. Steele
14. MOTHER'S MAIDEN NAME Effie M. Howell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Infant
16. SOCIAL SECURITY NO. —
17. INFORMANT "Mother"

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Intra Cranial hemorrhage. — INTERVAL BETWEEN ONSET AND DEATH 30 min.

760.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) — — — — —

160a (c) Rapid descent thru birth Canal.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION none
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-28, 1950, to 10-28, 1950, that I last saw the deceased alive on 10-28, 1950, and that death occurred at 1:40 P.m., from the causes and on the date stated above.

SIGNATURE H.C. Diehl, M.D. (Degree or title) ADDRESS Frostburg, Md. DATE SIGNED 10-28-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 10-30-50
NAME OF CEMETERY OR CREMATORY Porter Cemetery
LOCATION (City, town, or county) (State) Eckhart, Md.

DATE REC'D BY LOCAL REG. 11-1-50
REGISTRAR'S SIGNATURE Mrs. Nancy H. Roe
24. FUNERAL DIRECTOR Jacob Haper, ADDRESS Frostburg, Md.

2-0-0-28-0-38-3-39-6

RECEIVED
NOV 6 1950
BUREAU OF S

Dr. Tolson

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09871

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH**
COUNTY: ALLEGANY — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 18 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: MARYLAND — COUNTY: GARRETT
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: JENNINGS
STREET ADDRESS (If rural, give location):

**3. NAME OF DECEASED** (Type or Print): (First) CLARENCE E. (Middle) (Last) WHITE

**4. DATE OF DEATH**: (Month) Oct. (Day) 11, (Year) 1950

**5. SEX**: MALE

**6. COLOR OR RACE**: WHITE

**7. SINGLE, MARRIED, WIDOWED, DIVORCED** (Specify): married

**8. DATE OF BIRTH**: AUG. 12, 1876

**9. AGE last birthday**: 74 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Laborer

**10b. KIND OF BUSINESS OR INDUSTRY**: Saw Mill

**11. BIRTHPLACE** (State or foreign country): MARYLAND, Oakland

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: FRANKLIN WHITE

**14. MOTHER'S MAIDEN NAME**: SARAH RUSSELL

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No — (If yes, give war or dates of service):

**16. SOCIAL SECURITY No.**: 217-05-9914

**17. INFORMANT AND ADDRESS**: MEMORIAL HOSPITAL

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a): Benign hypertrophy prostate

610X

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b):

137a

(c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Chronic nephritis with terminal uremia

19a. DATE OF OPERATION: 10-4-50 — 19b. MAJOR FINDINGS OF OPERATION: Prostatectomy - benign hypertrophy — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-23-, 1950, to 10-11-, 1950, that I last saw the deceased alive on 10-11-, 1950, and that death occurred at 8:15 P.m., from the causes and on the date stated above.

SIGNATURE: Howard L. Tolson, M.D. (Degree or title) — ADDRESS: Cumberland Md — DATE SIGNED: 10-12-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Oct. 13 1950 — NAME OF CEMETERY OR CREMATORY: Grantsville Cem — LOCATION (City, town, or county) (State): Grantsville, Md

DATE REC'D BY LOCAL REG.: Oct. 13, 1950 — REGISTRAR'S SIGNATURE: Hunter R. Trantz, M.D. — 24. FUNERAL DIRECTOR: Wm A Winterberg — ADDRESS: Grantsville Md

4609

RECEIVED
OCT 18 1950
BUREAU V. I

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

09872

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural Cumberland
LENGTH OF STAY (in this place) 29 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS in auto, in route to Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Pa. COUNTY Bedford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Buck Valley
STREET ADDRESS (If rural give location) P.O. Little Orleans, Md.

3. NAME OF DECEASED (Type or Print) (First) Walter (Middle) Calvin (Last) Wigfield
4. DATE OF DEATH (Month) Oct. (Day) 5 (Year) 1950
5. SEX Male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH July 16-1890
9. AGE last birthday 60 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming
10b. KIND OF BUSINESS OR INDUSTRY Farm
11. BIRTHPLACE (State or foreign country) Fairview, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Nathan Wigfield
14. MOTHER'S MAIDEN NAME Jennie Ritz
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) w.w.1
16. SOCIAL SECURITY NO. ---
17. INFORMANT Mrs. Lela Wigfield

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| 241x | Immediate cause | (a) Acute cardiac failure due to | at once |
| 112 | Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Bronchial asthma | 7 yrs |
| | | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, occident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland, Md. DATE SIGNED Oct-6-1950

23. BURIAL, CREMATION REMOVAL (Specify) burial
DATE THEREOF 10-8-1950
NAME OF CEMETERY OR CREMATORY Cemetery Christian Church
LOCATION (City, town, or county) (State) Buck Valley, Pa.
DATE REC'D BY LOCAL REG. Oct. 6, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Charles Bast Funeral Home ADDRESS Hancock, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

I

T

RECEIVED
OCT 10 1950
BUREAU

Within corporate limits DR. TOLSON

# MARYLAND STATE DEPARTMENT OF HEALTH

09873

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND | LENGTH OF STAY (in this place) 6 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND — COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN FLINTSTONE, MD.
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) JAMES (Middle) WILLISON (Last)

4. DATE OF DEATH: (Month) OCT. (Day) 7. (Year) 1950

5. SEX: MALE | 6. COLOR OR RACE: WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED | 8. DATE OF BIRTH: NOV. 29. 1870 | 9. AGE last birthday: 79 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman-Retired
10b. KIND OF BUSINESS OR INDUSTRY: Wholesale foods
11. BIRTHPLACE (State or foreign country): MARYLAND Flintstone
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: ASHFORD WILLISON
14. MOTHER'S MAIDEN NAME: HARRIETT NEWELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carginoma of prostate
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) with liver & metastases
(c)

177X
51b

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-1-, 1950, to 10-7-, 1950, that I last saw the deceased alive on 10-6, 1950, and that death occurred at 5:25 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Howard L. Tolson M.D. | ADDRESS Cumberland Md | DATE SIGNED 10-7-50

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF Oct. 9 1950 | NAME OF CEMETERY OR CREMATORY Episcopal Cemetery | LOCATION (City, town, or county) Oakland. Md. (State)

DATE REC'D BY LOCAL REG. Oct. 8, 1950 | REGISTRAR'S SIGNATURE Winter R. Frantz M.D. | 24. FUNERAL DIRECTOR John J. Hafer, Cumberland. Md. | ADDRESS

23860

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 18 1950
BUREAU OF

Within corporate limits: DR. A. JONES

# MARYLAND STATE DEPARTMENT OF HEALTH

09874

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

I

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY ALLEGANY; STATE MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND; COUNTY ALLEGANY |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD. | LENGTH OF STAY (in this place): 67 years |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL | STREET ADDRESS (If rural, give location) 523 WASHINGTON STREET |

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| WILLIAM | L. | WILSON, SR. | OCT. | 26. | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | MARRIED | FEB. 12. 1883 | 67 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| STATE ROAD INSPECTOR | State of Maryland | MARYLAND | U S A |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| CONDA WILSON | AMANDA LANEY |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| No | | MEMORIAL HOSPITAL - CUMBERLAND, MD. |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Myocardial Failure | 4 wks |
| 422.2 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d | (b) Chronic Myocarditis | 2 yrs |
| | (c) | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | |

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐ |
|---|---|---|
| | | |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. I hereby certify that I attended the deceased from Apr., 1950, to Oct. 26, 1950, that I last saw the deceased alive on Oct. 25, 1950, and that death occurred at 1:25 A.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Arthur F. Jones M.D. | | 110 S. Centre St. | Oct. 26, 1950 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 28 1950 | Rose Hill Cem. | Cumberland Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 27, 1950 | Winter R. Frantz, M.D. | Louis Stein Inc. | Cumberland |

10678

RECEIVED
NOV 1 1950
BUREAU V. S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

09875

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: in route to
LENGTH OF STAY (In this place): MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Cumberland, Md. Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md.
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Gilmore
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) Richard (Middle) T (Last) Winner

4. DATE OF DEATH: (Month) Oct. (Day) 13 (Year) 1950

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: Aug 5 - 1945

9. AGE last birthday: 5 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): child

10b. KIND OF BUSINESS OR INDUSTRY: ----

11. BIRTHPLACE (State or foreign country): Midland, md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George A Winner

14. MOTHER'S MAIDEN NAME: Beulah Weir

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. George Winner

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH: 40 min.

Immediate cause (a) Abdominal hemorrhage due to a ruptured liver)

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

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170 C

(b) Intrathorax hemorrhage due to a ruptured lung from a fractured rib.

(c) Hit by an automobile.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes [X] No [ ]

21. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [X] CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
(CITY OR TOWN): Gilmore
(COUNTY): Allegany
(STATE): Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): Oct. 13/50 2.10 P. m.
INJURY OCCURRED While at work [ ] Not while at work [X]
HOW DID INJURY OCCUR? Ran across the road and was hit by an automobile.

22. *I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X] thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

SIGNATURE: H. V. Deming M.D. H. V. Deming M. D.
(Degree or title):
ADDRESS: Cumberland, Md.
DATE SIGNED: Oct. 13 - 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Oct 16-1950
NAME OF CEMETERY OR CREMATORY: St Anns Cemetery
LOCATION (City, town, or county) (State): Avilton, Garrett Co. Md.

DATE REC'D BY LOCAL REG.: Oct. 15, 1950
REGISTRAR'S SIGNATURE: Wister R. Hartz, M. D.
24. FUNERAL DIRECTOR: M. Eichhorn
ADDRESS: Lonaconing, Md.

RECEIVED
OCT 24 1950
BUREAU OF S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09876

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 429 N. Centre St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 429 N. Centre St.

3. NAME OF DECEASED (Type or Print): (First) William (Middle) Edward (Last) Yarnall

4. DATE OF DEATH: (Month) Oct. (Day) 20, (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Oct. 21, 1874

9. AGE last birthday: 75 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Car Distributor

10b. KIND OF BUSINESS OR INDUSTRY: R.R. B. & O.

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Peter Yarnall

14. MOTHER'S MAIDEN NAME: Mary Grannon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Mrs. Maurice Stegmier Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Acute Coronary Thrombosis | 3 hrs. |
| 430.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 51b | (b) Hypertension | |
| | (c) Arteriosclerosis | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Prostatic Carcinoma

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1950, to October, 1950, that I last saw the deceased alive on 20 Oct., 1950, and that death occurred at 5:12 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) James G. Stegmaier, M.D. ADDRESS 122 So. Centre St. DATE SIGNED 21 Oct. 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 10-23-1950
NAME OF CEMETERY OR CREMATORY: St. Patricks
LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG. Oct. 23, 1950
REGISTRAR'S SIGNATURE Victor R. Frantz, M.D.
24. FUNERAL DIRECTOR: Charles L. George ADDRESS: Cumberland, Md.

15647

RECEIVED
OCT 26 1950
BUREAU V. S

Within corporate limits.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09877

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH**
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 4 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Little Orleans
STREET ADDRESS (If rural, give location):

**3. NAME OF DECEASED** (Type or Print): (First) Anna (Middle) (Last) Young

**4. DATE OF DEATH**: (Month) Oct (Day) 4 (Year) 1950

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED** (Specify): Widow

**8. DATE OF BIRTH**: Mar 14 1876

**9. AGE** last birthday: 74 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Home duties

**10b. KIND OF BUSINESS OR INDUSTRY**: Home work

**11. BIRTHPLACE** (State or foreign country): Mason Co. W Va

**12. CITIZEN OF WHAT COUNTRY?**: US

**13. FATHER'S NAME**: James W McGowan

**14. MOTHER'S MAIDEN NAME**: Mary Ellen Fitzpatrick

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): no — (If year, give war or dates of service)

**16. SOCIAL SECURITY NO.**: None

**17. INFORMANT AND ADDRESS**: Mrs. James Ashbaugh Little Orleans Md

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a): Generalized Arteriosclerosis — Interval Between Onset and Death: Not Known

900.0

Antecedent cause(s)

186a

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b): Fracture of right femur — 4 Months

(c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION**:

**19b. MAJOR FINDINGS OF OPERATION**:

**20. AUTOPSY?** Yes ☐ No ☐

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify): Accident

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Home — (CITY OR TOWN): Little Orleans — (COUNTY): Allegany — (STATE): Md

TIME OF INJURY (Month) (Day) (Year) (Hour): 6-4-50 ?m.

INJURY OCCURRED While at Work ☐ Not While At work ☑

HOW DID INJURY OCCUR?: Fell while at Home (on Stairs)

**22.** I hereby certify that I attended the deceased from 6-6, 1950 to 10-4, 1950 that I last saw the deceased alive on 10-4, 1950, and that death occurred at 9 P.M., from the causes and on the date stated above.

SIGNATURE: J. E. Johnson — (Degree or title): M.D. — ADDRESS: Cumberland Md — DATE SIGNED: 10-5-50

**23. BURIAL, CREMATION, REMOVAL** (Specify): Burial — DATE: Oct 7 1950 — NAME OF CEMETERY OR CREMATORY: St Patricks Cemetery — LOCATION (City, town, or county) (State): Little Orleans Md

DATE REC'D BY LOCAL REG.: Oct. 6, 1950 — REGISTRAR'S SIGNATURE: Winter R. Wantz, M.D. — FUNERAL DIRECTOR: Chas R. Bast, Hancock Md — ADDRESS:

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OCT 10 1950
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